COVID-19

Weekly Screening Questionnaire

In order to continue providing the safest environment possible for our students, faculty and families, we ask that you fill out the below survey with information about your household and child prior to attending school each Monday. **Your child will not be allowed to attend class prior to completing this form**.

We will not permit anyone to attend class who answers yes to the below questions or has been to a state with positive COVID-19 testing rates exceeding 10 per 100,000 residents or higher than a 10% test positivity rate, in order to comply with current executive orders.

Child's Name: ________________________________ Age: __________

1. Has your child or anyone else in your household been outside of the country in the last 14 days?

   Yes (   ) No (   )
2. Has your child or anyone else in your household had close contact with anyone, who has been diagnosed with or who has had suspected symptoms of COVID-19 in the last 14 days?

   Yes (   ) No (   )
3. Has your child or anyone in your household experienced any cold or flu like symptoms or tested positive for COVID-19 in the last 14 days?

   Yes (   ) No (   )
4. Has your child or anyone else in your household been outside the state of New York in the last 14 days?

   Yes (   ) No (   )

   If yes, what state? ____

____ ______________

Parent Signature Date

Cell phone number: ________________________________

Email address: ____________________________________

Perrotta Consulting LLC

Threat Mitigation and Emergency Operation Planning

Thank you