

STOCKBRIDGE VALLEY CENTRAL SCHOOL

COVID-19 VISITOR SCREENING

IN THE PAST 14 DAYS HAVE YOU OR ANYONE IN YOUR HOUSEHOLD BEEN TESTED OR TESTED POSITIVE FOR COVID-19?

YES NO

IN THE PAST 14 DAYS HAVE YOU BEEN IN CLOSE CONTACT WITH ANYONE WHO HAS A CONFIRMED CASE OF COVID-19 OR HAS DEMONSTRATED SYMPTOMS OF CORONAVIRUS?

YES NO

IN THE PAST 3 DAYS HAVE YOU EXPERIENCED ANY SYMPTOMS OF COVID 19 - SHORTNESS OF BREATH, EXCESSIVE COUGHING, DIFFICULTY BREATHING OR A FEVER IN EXCESS OF 100 DEGREES?

YES NO

IN THE PAST 14 DAYS HAVE YOU OR ANYONE IN YOUR HOUSEHOLD TRAVELED INTERNATIONALLY OR TO ANY STATE IDENTIFIED ON NEW YORK STATE'S REQUIRED TRAVEL QUARANTINE LIST?

YES NO

TEMPERATURE CHECK: PASS FAIL

DATE: _____ PRINT NAME: _____ PHONE NUMBER: _____

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