STOCKBRIDGE VALLEY CENTRAL SCHOOL-DAILY COVID-19 STUDENT SCREENING

IN THE PAST 14 DAYS HAVE YOU OR ANYONE IN YOUR HOUSEHOLD 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

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

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

DOES YOUR CHILD CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS OF COVID-19: FEVER, COUGH, SHORTNESS OF BREATH, MUSCLE OR BODY ACHES, HEADACHE, NEW LOSS OF TASTE OR SMELL, SORE THROAT, CONGESTION OR RUNNY NOSE, NAUSEA, VOMITING, OR DIARRHEA?

YES NO

******If you answered "YES" to any of these questions, please keep your child home******

DATE:_____ STUDENTS NAME:_____ PARENT SIGNATURE:_____**.**

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