Whitney Point COVID-19 Screening Tool for Students

Name of Child: _____

School: _____

Grade: _____

I understand that I am required to submit this questionnaire and answer all four questions below on the first day of each week for my child. I also agree to screen my child daily for symptoms (see question #3) or exposure to COVID-19. If my child has symptoms, COVID-19 exposure or a positive test, I will keep him/her home and report it to the school nurse.

I understand and agree to the above statement.

Parent Name: _____ Parent Signature: _____

Date: _____

Please answer the following four questions:

1. **Has your child knowingly been in close or proximate contact days with anyone who has tested positive through a diagnostic test for COVID-19 or who has symptoms of COVID-19 in the past 14 days?**

   _____ Yes _____ No

2. **Has your child tested positive through a diagnostic test for COVID-19 in the past 14 days?**

   _____ Yes _____ No

3. **Has your child experienced any symptoms of COVID-19, including a temperature of greater than 100.0 ° F, sore throat, new uncontrolled cough, new onset of severe headache, diarrhea, vomiting, or abdominal pain in the last 14 days?**

   _____ Yes _____ No

4. **Has your child traveled internationally or from a state with widespread community transmission of COVID-19 per the New York State Travel Advisory in the past 14 days?**

   _____ Yes _____ No

Please return a completed form on the first day of each week to the school main office.