Scarsdale Public Schools

COVID-19 Student Screening Questionnaire

Student's Name: _____

Please complete one (1) form for each child	**YES**	**NO**
Has your child experienced any symptoms of COVID-19 in the past 14 days? ■ Fever or chills (100°F / 37.8C or greater) ■ Cough ■ Shortness of breath or difficulty breathing ■ Fatigue ■ Muscle or body aches ■ Headache ■ New loss of taste or smell ■ Sore Throat ■ Congestion or runny nose ■ Nausea or vomiting ■ Diarrhea		
Has your child knowingly been in close or proximate contact in the past 14 days with anyone who has tested positive through a diagnostic test for COVID-19 or who has or had symptoms of COVID-19?		
Has your child tested positive through a diagnostic test for COVID-19 in the past 14 days?		
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?		

Date: _____ **Parent/Guardian Signature:** _____