Baldwinsville
Central School District
Achieving our full potential together.

STUDENT COVID-19 Health Screening Questionnaire

Student Name: _____Grade: ____ Teacher: _____

Date of In-person Attendance at School: _____

❑ **Yes**	❑ **No**	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?
❑ **Yes**	❑ **No**	Has your child tested positive through a diagnostic test for COVID-19 in the past 14 days?
❑ **Yes**	❑ **No**	Has your child experienced any symptoms* of COVID-19, including a temperature of greater than 100.0 degrees Fahrenheit in the past 14 days? ***Common Symptoms of COVID-19: Fever or chills; 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; and/or diarrhea.***
Temperature _____ °F		
❑ **Yes**	❑ **No**	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 for more than 24 hours?

If you have indicated YES for your child to any of the screening questions, your child is not permitted to attend school. *If your child develops any symptoms of COVID-19 while on school grounds or during transport, you will immediately be notified and be required to pick-up or make arrangements to pick-up your child. In either case, you will be required to obtain medical clearance from your healthcare provider for your child prior to a return to school.*

Parent/Guardian Name (PRINT): _____

Signature:_____Date:_____

Contact number during school hours: _____

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