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 student tested positive through a diagnostic test for COVID-19 in the past 10 days, or are you awaiting a test result?
❑ **Yes**	❑ **No**	In the last 10 days have you been notified your student has had contact with a person who has tested positive for COVID-19?
❑ **Yes**	❑ **No**	In the last 10 days has your student traveled internationally to a CDC Level 2 or higher COVID-19 related travel health notice country?
❑ **Yes**	❑ **No**	Does your student currently have (or has had in the last 10 days) one or more of these new or worsening symptoms of COVID-19?
Temperature _____ °F		***A temperature of greater than or equal to 100.0 degrees Fahrenheit*** ***Feel feverish or have chills*** ***Cough*** ***Loss of taste or smell*** ***Fatigue/feeling or tiredness*** ***Sore throat*** ***Shortness of breath or trouble breathing*** ***Nausea, vomiting, diarrhea*** ***Muscle pain or body aches*** ***Headaches*** ***Nasal congestion/runny nose***

If you have indicated YES for your student to any of the screening questions, your student is not permitted to attend school. *If your student 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 student. In either case, you will be required to obtain medical clearance from your healthcare provider for your student prior to a return to school.*

Parent/Guardian Name (PRINT): _____

Signature:_____Date:_____

Contact number during school hours: _____

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