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 tested positive through a diagnostic test for COVID-19 in the past 10 days?
❑ **Yes**	❑ **No**	In the last 14 days, has your student been designated a contact of a person who tested positive for COVID-19 by a local health department?
❑ **Yes**	❑ **No**	In the last 14 days, has your student traveled internationally or to a state or territory on the NYS Travel Advisory List?
❑ **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? ***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***
Temperature _____ °F		

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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