

Health Screening Form



Date: ____ / ____ / ____

Name: _____

Grade: _____

- 1) Is the child/person entering the building currently experiencing, or has experienced in the past 10 days, any of the following symptoms:

- | | |
|---|----------------------------|
| - Fever of 100.0F/37.8C or more | - Headache |
| - Chills | - Muscle or body aches |
| - Cough | - Fatigue |
| - Shortness of breath or difficulty breathing | - Sore throat |
| - New loss of taste or smell | - Congestion or runny nose |
| - Nausea or vomiting | - Diarrhea |

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No

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Yes

- 2) Has the child/person entering the building had a positive COVID-19 test in the last 14 days or are presently waiting for the results of a COVID-19 test?

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No

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Yes

- 3) Has the child/person entering the building, or a sibling also attending GISNY, had close contact with a confirmed or suspected case of COVID-19 case in the last 14 days?

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No

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Yes

- 4) Has the child/person entering the school building traveled outside New York State/NYC metropolitan area in the past 7 days **AND** followed the CDC travel guidance?

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Did Not Travel

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Yes

Information for Vaccinated and Unvaccinated International and Domestic Travelers:

Effective 8/25/21, the CDC has updated their guidance for vaccinated and unvaccinated international & domestic travelers. For more information, please click on the links below:

International Travel: <https://www.cdc.gov/coronavirus/2019-ncov/travelers/international-travel-during-covid19.html>

Domestic Travel: <https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-during-covid19.html>

Signature: _____

Parent/Legal Guardian/Student over 18