Health Screening Form

Date: _____ / _____ / _____

Student Name: _____

Grade: _____

1) Is the child/person entering the building currently experiencing, or has experienced in the past 14 days, any of the following symptoms:
   - Fever of 100.0F/37.8C or more
   - Chills
   - Cough
   - Shortness of breath or difficulty breathing
   - New loss of taste or smell
   - Nausea or vomiting
   - Headache
   - Muscle or body aches
   - Fatigue
   - Sore throat
   - Congestion or runny nose
   - Diarrhea

   ☐ No ☐ 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?

   ☐ No ☐ 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?

   ☐ No ☐ Yes

4) Has the child/person entering the building traveled internationally or to any state that the state of New York requires a quarantine, or been in 'close contact' with someone that was quarantined without being isolated during the last 14 days?

   ☐ No ☐ Yes

5) Since last coming to school, has your child/the person entering the building had a COVID test without having had symptoms (Asymptomatic/Surveillance Screening)? ***Please note that the answer to this question will not be included in your overall point for this survey.***

   ☐ No ☐ Yes

Signature: _____

Parent/Legal Guardian/Student over 18