



# Edgemont Public Schools

## COVID-19 Student Screening Questionnaire

Student's Name: \_\_\_\_\_ Grade Level: \_\_\_\_\_ Teacher: \_\_\_\_\_

Please complete one (1) form for each child	YES	NO
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<p>Has your child experienced any symptoms of COVID-19 in the past 14 days?</p> <ul style="list-style-type: none"><li>■ Fever or chills (100°F / 37.8C or greater)</li><li>■ Cough</li><li>■ Shortness of breath or difficulty breathing</li><li>■ Fatigue</li><li>■ Muscle or body aches</li><li>■ Headache</li><li>■ New loss of taste or smell</li><li>■ Sore Throat</li><li>■ Congestion or runny nose</li><li>■ Nausea or vomiting</li><li>■ Diarrhea</li></ul>		
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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?		
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Has your child tested positive through a diagnostic test for COVID-19 in the past 14 days?		
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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?		
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Date: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_