PELHAM PUBLIC SCHOOLS
COVID STUDENT HEALTH QUESTIONNAIRE

Student: ___________________________ Date: _______

If your child has tested positive in the last 90 days and has recovered or is fully vaccinated, please skip Question 2.

1. Has your child tested positive for COVID-19 in the past 10 days?	O Yes O No
2. Has your child had close contact with someone with a confirmed positive COVID-19 in the past 10 days?	O Yes O No
3. Does your child have any of the symptoms below? ● Congestion or runny nose ● Cough ● Sore throat ● Fatigue ● Headache ● Diarrhea ● Muscle or body aches ● Shortness of breath or difficulty breathing ● New loss of taste or smell ● Nausea or vomiting	O Yes O No
4. Does your child have a fever (100.0°F or greater) or had a fever in the last 24 hours?	O Yes O No

*If you answered **YES** to any of the above questions, your child will not be able to come to school today. Please contact your child's school nurse for questions or further guidance. Your signature below indicates that you have answered the above questions truthfully.*

____
Parent/Guardian's Name

____
Parent/Guardian's Signature

Updated 5.5.2021

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