

PELHAM PUBLIC SCHOOLS COVID STUDENT HEALTH QUESTIONNAIRE

Student: _____ Date: _____

1. Has your child tested positive for COVID-19 in the past 14 days?	<input type="radio"/> Yes <input type="radio"/> No		
2. Has your child had close contact with someone with a confirmed positive COVID-19 in the past 14 days?	<input type="radio"/> Yes <input type="radio"/> No		
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none; vertical-align: top;"> <ul style="list-style-type: none"> ● Fever (100.0°F or greater) or chills ● Congestion or runny nose ● Cough ● Sore throat ● Fatigue ● Headache </td> <td style="width: 50%; border: none; vertical-align: top;"> <ul style="list-style-type: none"> ● Muscle or body aches ● Shortness of breath or difficulty breathing ● New loss of taste or smell ● Nausea or vomiting ● Diarrhea </td> </tr> </table>	<ul style="list-style-type: none"> ● Fever (100.0°F or greater) or chills ● Congestion or runny nose ● Cough ● Sore throat ● Fatigue ● Headache 	<ul style="list-style-type: none"> ● Muscle or body aches ● Shortness of breath or difficulty breathing ● New loss of taste or smell ● Nausea or vomiting ● Diarrhea 	
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3. Does your child have any of the symptoms above?	<input type="radio"/> Yes <input type="radio"/> No		
4. Does your child have a fever (100.0°F or greater) or had a fever in the last 24 hours?	<input type="radio"/> Yes <input type="radio"/> No		
5. Has your child traveled internationally or to a state identified under NY's travel restriction within the last 14 days, thereby requiring a 14-day quarantine?	<input type="radio"/> Yes <input type="radio"/> No		

*If you answered **YES** to any of the above questions, your child will not be able to come to school today. Your signature below indicates that you have answered the above questions truthfully.*

Parent/Guardian's Name

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