PELHAM PUBLIC SCHOOLS
COVID STUDENT HEALTH QUESTIONNAIRE

Student: _____ **Date:** _____

1. Has your child tested positive for COVID-19 in the past 14 days?	O Yes O No
2. Has your child student had any close contact with someone with a confirmed positive COVID-19 or is showing symptoms (below) of COVID-19 in the past 14 days?	O Yes O No
● Fever (greater than 100°F) or chills ● Congestion or runny nose ● Cough ● Sore throat ● Fatigue ● Headache ● Muscle or body aches ● Shortness of breath or difficulty breathing ● Loss of taste or smell ● Nausea, vomiting or diarrhea	
3. Does your child have any of the symptoms above?	O Yes O No
4. Does your child have a fever (greater than 100°F) or had a fever in the last 24 hours?	O Yes O 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?	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. Your signature below indicates that you have answered the above questions truthfully.*

_____

Parent/Guardian's Name

_____

Parent/Guardian'sSignature

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