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 had close contact with someone with a confirmed positive COVID-19 in the past 14 days?	O Yes O No
3. Does your child have any of the symptoms below? ● Fever (100.0°F or greater) or chills ● Congestion or runny nose ● Cough ● Sore throat ● Fatigue ● Headache ● Muscle or body aches ● Shortness of breath or difficulty breathing ● New loss of taste or smell ● Nausea or vomiting ● Diarrhea	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
5. Has your child traveled to states that are NOT contiguous to NYS for more than 24 hours within the last 14 days, and **NOT "tested out"** of quarantine by completing the required testing?	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 11.9.2020

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