**PELHAM PUBLIC SCHOOLS**
**VISITOR COVID-19 HEALTH SCREENING**

**Name:**_____ **Date:**_____ **Time:**_____

**Please complete this screening prior to entering the building. Screening information will only be used to determine eligibility to enter the building.**

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|---|---|
| 1. Have you tested positive for COVID-19 in the past 10 days? | O Yes O No |
| 2. Have you had close contact with someone with a confirmed positive COVID-19 in the past 10 days? | O Yes O No |
| 3. Do you currently have any of the symptoms below?<br>● Fever (100.0°F or greater) or chills<br>● Congestion or runny nose<br>● Cough<br>● Sore throat<br>● Fatigue<br>● Headache<br>● Muscle or body aches<br>● Shortness of breath or difficulty breathing<br>● New loss of taste or smell<br>● Nausea or vomiting<br>● Diarrhea | O Yes O No |
| 4. Have you had a fever (100.0°F or greater) in the last 24 hours? | O Yes O No |
| 5. If you have traveled out of the country within the last 10 days, did you get a negative COVID test result taken between 3 to 5 days after arrival and quarantined for 7 days? | O Yes O No |

*If you answered **YES** to any of the questions above, you are **NOT** allowed to enter the building.*

*Your signature below indicates that you have answered the above questions truthfully.*

**Signature:** _____