Visitor Health Screening Form
(PLEASE PRINT)

Date: _____ / _____ / _____

Last Name: _____ First Name: _____

Address: _____

Email: _____

Phone: _____

1) Are you currently experiencing, or have you experienced in the past 10 days, any of the following symptoms:
   - Fever of 100.0F/37.8C or more
   - Chills
   - Cough
   - Shortness of breath or difficulty breathing
   - New loss of taste or smell
   - Nausea or vomiting
   - Headache
   - Muscle or body aches
   - Fatigue
   - Sore throat
   - Congestion or runny nose
   - Diarrhea

   ☐ No ☐ Yes

2) Have you had a positive COVID-19 test in the last 14 days or are presently waiting for the results of a COVID-19 test?

   ☐ No ☐ Yes

3) Have you had close contact with a confirmed or suspected case of COVID-19 case in the last 14 days?

   ☐ No ☐ Yes

4) Has the child/person entering the school building traveled outside New York State/NYC metropolitan area in the past 7 days **AND** followed the CDC travel guidance?

   ☐ Did Not Travel ☐ Yes

   Information for Vaccinated and Unvaccinated International and Domestic Travelers:

   Effective 8/25/21, the CDC has updated their guidance for vaccinated and unvaccinated international & domestic travelers. For more information, please click on the links below:

   International Travel: https://www.cdc.gov/coronavirus/2019-ncov/travelers/international-travel-during-covid19.html

   Domestic Travel: https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-during-covid19.html

Signature: _____

(*Students under the age of 18 require a signature by their parent or legal guardian*)