## 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<br>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<br>O No |
| • Fever (greater than 100°F) or chills<br>• Congestion or runny nose<br>• Cough<br>• Sore throat<br>• Fatigue<br>• Headache | • Muscle or body aches<br>• Shortness of breath or difficulty breathing<br>• Loss of taste or smell<br>• Nausea, vomiting or diarrhea | |
| 3. Does your child have any of the symptoms above? | | O Yes<br>O No |
| 4. Does your child have a fever (greater than 100°F) or had a fever in the last 24 hours? | | O Yes<br>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<br>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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