Self-Screening Health Questionaire

To be filled out daily by employees, parents, children and essential visitors

Name: ________________________   Date: ___________

Parent/Guardians name: _______________________
If filling out for a child write sign your name

1. Is your temperature higher than or equal to 100.0 Fahrenheit?   Yes____   No____

2. Have you had any known contact with a person confirmed or suspected to have COVID-19 in the past 14 days?   Yes____   No____

3. Are you currently experiencing ANY of the following symptoms? If no, check None of the Above (the last option)

- Cough (new or worsening) ____
- Shortness of breath (new or worsening) ____
- Trouble breathing ____
- Fever ____
- Chills ____
- Muscle Pain (new or worsening) ____
- Headache (new or worsening) ____
- Sore Throat (new or worsening) ____
- New loss of taste ____
- New Loss of smell ____
- None of the above _____

4. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?   Yes____ No____

5. In response to increased rates of COVID-19 transmission in certain states within the United States, and to protect New York's successful containment of COVID-19, the State has joined with New Jersey and Connecticut in jointly issuing a travel advisory for anyone returning from travel to states that have a significant degree of community-wide spread of COVID-19. **These states include Alabama, Arkansas, Arizona, California, Florida, Georgia, Iowa, Idaho, Louisiana, Mississippi, Nevada, North Carolina, South Carolina, Tennessee, Texas and Utah.**

In the last 14 days have you visited a state where COVID-19 is spreading: Yes____   No____

6. In the last 14 days, have you visited a country where COVID-19 is spreading?   Yes ____   No____

Reviewed By (do not sign, for office use only) ________________________________