

Health Screening Form

NAME: _____ (SCHSHL) DATE: _____

1. Do you currently have a fever of 100.4 degrees F or greater?

- No. Go to the next question. Yes. No further screening is needed. Entry is not permitted.

2. Have you had any of these symptoms in past 14 days?

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Muscle or body aches
- New loss of taste or smell
- Nausea or vomiting
- Diarrhea

Temperature

- No. Go to the next question. Yes. No further screening is needed. Entry is not permitted.

3. Have you been in contact with a person who has COVID-19 in the past 14 days?

- No. Yes. No further screening is needed. Entry is not permitted.

4. Have you had a positive COVID -19 test in the past 14 days?

- No. Yes. No further screening is needed. Entry is not permitted.

5. Have you or a household family member left New York State in the past 14 days?

- No. Yes. Where? _____ Reason? _____ Entry may not permitted.

I agree that all answers above are accurate and truthful:

Signature : _____ Date: _____