Seneca Falls CSD
Educating the Whole Child

COVID-19 Health Screening

Daily Health Screening Form

Please complete the following form before entering the building. If you do not have a fever but you are experiencing any of the other symptoms and those symptons are not normal to you because of an underlying condition such as migraines, allergies, etc., please stay home and don't put others in jeopardy and consult a healthcare professional . If the answer is yes to any of the questions on the screening form, you will not be allowed to enter the building and directed to contact a health care professional.

Date: ________________________

This form applies to:

Student Name	Student Grade

In the last 14 days, has anyone in your household had close contact with someone who has or is suspected to have COVID-19?

☐ Yes ☐ No

In the last 48 hours, has your child(ren) experienced any of the following symptoms?
Fever (over 100.0 °F)

☐ Yes ☐ No

Headache

☐ Yes ☐ No

Cough

☐ Yes ☐ No

Sore Throat

☐ Yes ☐ No

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Parent/Guardian Initials

Shortness of Breath

☐ Yes ☐ No

Chills

☐ Yes ☐ No

Muscle Aches

☐ Yes ☐ No

Loss of Taste or Smell

☐ Yes ☐ No

Gastrointestional
(nausea, vomiting or diarrhea)

☐ Yes ☐ No

Your Name	**Email**	**Phone**

Parent/Guardian Signature