CHESTER UNION FREE SCHOOL DISTRICT

Health Screening Questionnaire

School: ☐ Chester Elementary School **Today's Date:** _____
☐ Chester Academy

First Name: _____ **Last Name:** _____
Check One: ☐ Parent
☐ Faculty/Staff
☐ Other: _____

Email Address: _____

	Yes	No
Do you have a fever today (over 100°)?	Yes	No
According to the *US Centers for Disease Control and Prevention* and the *World Health Organization*, Covid 19 symptoms include: • fever or chills cough shortness of breath or difficulty breathing • fatigue • muscle or body aches • headache • new loss of taste or smell • sore throat • congestion or runny nose • nausea or vomiting • diarrhea Are you experiencing any of the Covid 19 related symptoms noted above?	Yes	No
Are you living with or caring for an individual who is suspected or confirmed case of Covid 19?	Yes	No
Have you tested positive for Covid 19 in the last 14 days?	Yes	No
Have you traveled outside of New York State the past 14 days?	Yes	No
I certify that all the information provided is shared to the best of my ability.		
Signature: _____		