

*Wynantskill UFSD*  
**COVID-19 DAILY SCREENING QUESTIONS**

*Please assess your child each morning and complete this form. If the answer for your child is YES to any of these questions, please keep your child home from school and contact our school nurse and your doctor.*

<b>Does your child have a fever (temperature over 100.0° F) without having taken any fever-reducing medications?</b>	YES	NO
<b>New uncontrolled cough that causes difficulty breathing (for students with chronic allergic/asthmatic cough, a change in their cough from baseline)</b>	YES	NO
<b>Does your child have a loss of smell or taste?</b>	YES	NO
<b>Does your child have muscle aches?</b>	YES	NO
<b>Does your child have a sore throat?</b>	YES	NO
<b>Does your child have congestion or a runny nose?</b>	YES	NO
<b>Does your child have shortness of breath?</b>	YES	NO
<b>Does your child have chills?</b>	YES	NO
<b>Does your child have a headache?</b>	YES	NO
<b>Has your child experienced any new gastrointestinal symptoms such as nausea, vomiting, diarrhea, or loss of appetite in the last few days?</b>	YES	NO
<b>Have you knowingly been in close or proximate contact in the past 14 days with anyone who has tested positive for COVID-19?</b>	YES	NO
<b>Have you knowingly been in close or proximate contact in the past 14 days with anyone who has or had symptoms of COVID-19?</b>	YES	NO
<b>Have you tested positive for COVID-19 in the last 14 days?</b>	YES	NO