RESIDENTIAL AND DAY SCHOOL

HEALTH SURVEY

Students/Parents/Other

By completing this form, I certify that in the last 14 days:

1) I have not had a fever of 100.4 degrees F (38 degrees C) or higher.
2) I have not experienced symptoms such as cough, difficulty breathing, and loss of sense of smell or taste.
3) Neither I nor anyone with whom I've had close contact with, has been notified about possible exposure to a confirmed case of COVID-19. Close contact means direct contact with infectious secretions (e.g., being coughed on) or being within 6 feet (2 meters) for a prolonged time, and
4) I have not traveled out of the United States or the states on the New York State advisory list.

If you cannot confirm all of the above as true **STOP**. A supervisor or nurse will assess your health survey before you can proceed. You may be asked to leave the building or be isolated from others.

I certify that all of the above is true:

Print Name: _____ Signature: _____ Date: _____

Reviewed by: _____ Signature: _____ Date: _____

TEMPERATURE SCREENING DONE: _____
Initial

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