# COVID Screening Form

**Student Name:** _____

**Parent/Guardian Name:** _____

**Contact Phone Number:** _____

Do I or my child currently have a temperature of 100.4°F or above?

□ No □ Yes. If so, you/they cannot participate in PREP today.

Do I or my child have any of these symptoms of COVID-19?
*(Fever of 100.4°F or higher, Cough, Chills, Shortness of breath/difficulty breathing, Loss of taste or smell, Congestion/runny nose, Nausea/vomiting/diarrhea, Muscle/body aches, Fatigue, Sore throat, Headache)*

□ No □ Yes. If so, you/they cannot participate in PREP today.

Have you or your child knowingly been near someone in the past 14 days with anyone who has tested positive for COVID-19 or has or had symptoms of COVID-19?

□ No □ Yes. If yes, you/they cannot participate in PREP today.

Have you or your child tested positive for COVID-19 in the past 14 days?

□ No □ Yes. If yes, you/they cannot participate in PREP today.

Have you or your child traveled internationally or from a state with widespread community transmission of COVID-19 per the New York State Travel Advisory in the past 14 days?

□ No □ Yes. If yes, you/they cannot participate in PREP today.

**By signing this, I attest that all answers are true to the best of my knowledge.**

**Signature** _____ **Date** _____

**FOR OFFICE USE ONLY**

□ Parent Meeting □ Student Meeting □ Staff Meeting □ Communion □ Confirmation
□ Church □ School