



COVID-19 QUESTIONNAIRE

EVERY PARENT/S MUST FILL OUT OUR COVID-19 SURVEY ONCE A MONTH and submit via email.

Parent Full Name: _____

Student Full Name: _____

Q1: Does you child currently have temperature of 100.4 degrees?

YES NO

Q2: In the past 24 hours, has your child experienced:

- fever
- fatigue
- frequent, dry cough
- aches and pains
- sore throat
- diarrhea
- headaches
- shortness of breath
- loss of smell or taste

Q3: Has your child recently been in contact with anyone who has exhibited any of these symptoms?

YES NO

Q4: Has your child recently been in contact with anyone who has tested positive for COVID-19?

YES NO

Q5: Has your child travelled outside NY state in the past 14 days?

YES NO

Parent Signature: _____

Date: _____