



## VCSD Daily Screening Questionnaire

*All staff and students will be screened prior to entering any VCSD building.  
Only those identified as **CLEARED** will be permitted to enter the building.*

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

School Building or Department\* \_\_\_\_\_ Grade\* \_\_\_\_\_

\*If applicable

<i>Today:</i>	CHECK ONE	
Was your daily temperature check <b>OVER 100°F</b> ?	Yes	No

<i>In the past 10 days, have you</i>	CHECK ONE	
Tested positive for COVID-19?	Yes	No

<i>In the past 14 days, have you:</i>	CHECK ONE	
Experienced COVID-like symptoms <u>NOT</u> related to a chronic health condition? These can include the following: <ul style="list-style-type: none"> <li>• Fever or chills</li> <li>• Cough</li> <li>• Shortness of breath or difficulty breathing</li> <li>• Fatigue</li> <li>• Muscle or body aches</li> <li>• Headache</li> <li>• New loss of taste or smell</li> <li>• Sore throat</li> <li>• Congestion or runny nose</li> <li>• Nausea or vomiting</li> <li>• Diarrhea</li> </ul>	Yes	No
Had any close contact with confirmed or suspected cases of COVID-19?	Yes	No
Traveled internationally or from a state with widespread community transmission of COVID-19 per the New York Travel Advisory?	Yes	No

Source: Centers for Disease Control and Prevention: <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>

<i>Today's results:</i>	CHECK ONE
If you answered YES to <b>ANY</b> of the above questions you are:	<b>NOT CLEARED</b>
If you answered NO to <b>ALL</b> of the above questions you are:	<b>CLEARED</b>

Signature: \_\_\_\_\_

Signature of Parent/Guardian if under 18 years \_\_\_\_\_