Revised 4/01/21

VCSD Daily Screening Questionnaire

All staff and visitors will complete and present this form upon entering any VCSD building. Only those identified as CLEARED will be permitted to enter the building.

Name: _____ Today's Date: _____

School Building/Department:* _____ Grade:* _____

***If Applicable**

Today:	CHECK ONE	
Was your daily temperature check OVER 100°F?	☐ Yes	☐ No
Are you or a member of your household awaiting COVID-19 test results?	☐ Yes	☐ No

In the past 10 days, have you	CHECK ONE	
Tested positive for COVID-19?	☐ Yes	☐ No
Have you experienced one or more of these symptoms, new or worsening, and not related to a chronic health condition? These can include the following: • Temperature greater than, or equal to, 100.0° F • Feel feverish or have chills • Cough • Loss of taste or smell • Fatigue/Feeling of tiredness • Sore throat • Shortness of breath or difficulty breathing • Nausea, vomiting or diarrhea • Muscle pain or body aches • Headaches • Nasal congestion/Runny nose Source: NYS Department of Health Pre-K to Gr 12 COVID-19 Toolkit; February 2021	☐ Yes	☐ No
Been designated a contact of a person who tested positive for COVID-19 by a local health department?	☐ Yes	☐ No
Traveled internationally, per the New York Travel Advisory?	☐ Yes	☐ No

Today's results:	CHECK ONE
If you answered YES to ***ANY*** of the above questions you are:	☐ NOT CLEARED
If you answered NO to ***ALL*** of the above questions you are:	☐ CLEARED

Your Signature: _____

Signature of Parent/Guardian, if under 18 years: _____