



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 ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you or a member of your household awaiting COVID-19 test results due to symptomatic conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

In the past <u>10</u> days, have you	CHECK ONE	
Tested positive for COVID-19?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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: <ul style="list-style-type: none"> • 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 	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Source: NYS Department of Health Pre-K to Gr 12 COVID-19 Toolkit; February 2021		
Been designated a contact of a person who tested positive for COVID-19 by a local health department?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Traveled internationally, per the New York Travel Advisory?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Today's results:	CHECK ONE
If you answered YES to ANY of the above questions you are:	<input type="checkbox"/> NOT CLEARED
If you answered NO to ALL of the above questions you are:	<input type="checkbox"/> CLEARED

Your Signature: _____

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