

Mount Sinai Schools

Student Admittance Health Questionnaire

PLEASE HELP US KEEP OUR SCHOOLS SAFE.

Parents/Caregivers **MUST** complete, sign and students must turn in this form in order to enter school. **Students who do not have this form will be screened by school personnel prior to starting their school day. No Exceptions will be made.**

Student First Name

Student Last Name

Grade

Student temperature prior to departing for school (Fahrenheit): _____ Time taken: _____ A.M.

1. Does the student live in the same household or have close contact with someone who, in the last 14 days, has been in isolation for COVID-19 or had a test confirming the virus?
Circle: **Yes No**

2. Has the student tested positive for COVID-19 within the last 14 days?
Circle: **Yes No**

3. Have you or a family member traveled from a state on the current "New York Travel Advisory List" or internationally in the past 14 days?
Circle: **Yes No**

4. Has the student exhibited any of the following symptoms today (or within the last 24 hours) which cannot be better explained by another condition? (Circle Below)

Fever:	Yes	No	Cough:	Yes	No
Difficulty Breathing:	Yes	No	Muscle Aches or Pain:	Yes	No
Chills:	Yes	No	Sore Throat:	Yes	No
Unusually Weak/Fatigued:	Yes	No	Runny/Congested Nose:	Yes	No
Repeated Shaking/Shivering:	Yes	No	Shortness of Breath:	Yes	No
Loss of Taste or Smell:	Yes	No	Diarrhea:	Yes	No

Please provide additional information below if symptoms present are better explained by another condition (e.g. exercise induced muscle soreness, diagnosed seasonal allergies):

If the student is experiencing any of the above symptoms, without an explanation not related to possible COVID-19, the student is required to STAY HOME from school until symptom free or documentation of a negative COVID-19 test.

I certify to the best of my knowledge; this information is accurate.

Parent/Caregiver full name printed

Date

Parent/Caregiver signature

revised 9/25/2020