FOR SCCNS STAFF ONLY

Temperature screen completed / passed:

_____
(initial only)

SCCNS Health Screen

Please complete at the start of each week and hand to the staff member conducting your child's entry screening.

In the event that your answers to any of the below change throughout the week, it is expected that you communicate this to SCCNS as soon as possible.

In the past 72 hours, have you or the student in your care experienced:

YES ☐ NO ☐ Fever of 100.0 or greater

YES ☐ NO ☐ Shortness of breath

YES ☐ NO ☐ Sore throat

YES ☐ NO ☐ Chills / General feeling of malaise

In the past 14 days, have you or the student in your care:

YES ☐ NO ☐ Had close contact with anyone recently diagnosed with COVID-19?

YES ☐ NO ☐ Travelled to any states or regions on the NYS Travel Advisory list?

If you answered YES to any of the above, please do not send the student into school. Self-isolate at home and contact your or your child's physician for direction.

Print Child(ren) Name: _____

Parent or Guardian Signature / Date: _____/_____

Print Parent or Guardian Name: _____