



COVID-19 Student Screening Ticket

Child's Name _____

Today's Date _____

(One ticket per student. Please present this to the bus driver or door monitor.
This ticket is required for entry.)

Please read these five questions carefully and provide an answer below:

1. Has your child knowingly been in close or proximate contact in the past 14 days with anyone who has tested positive for COVID-19 or had symptoms of COVID-19?
2. Has your child had a positive diagnostic test for COVID-19 in the past 14 days?
3. Has your child experienced any symptoms of COVID-19, including dry cough, shortness of breath, loss of sense of smell or taste, nausea, vomiting, or diarrhea?
4. Has your child experienced a temperature of greater than 100.0°F in the past 14 days?
5. Has your child traveled internationally or from a state with widespread community transmission of COVID-19 per the New York State Travel Advisory in the past 14 days?

___ **NO** to **ALL** of the questions above ___ **YES** to **ANY** of the questions above

By signing below, I swear that this information is true and that I understand falsifying information is a violation of the district's code of conduct. I also understand that if the answer is **YES** to **any** of the questions above, I am **REQUIRED** by state executive order to keep my child home from school and contact our health care provider immediately.

Parent/Guardian's Name & Signature



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