WEST GENESEE CENTRAL SCHOOL DISTRICT
STUDENT DAILY HOME SCREENING QUESTIONS

Date: _____ Name: _____

Temperature was checked this morning and it was less than 100.0 F

In the last 14 days, my child HAS NOT:

☐ Experienced ANY of the following symptoms of COVID-19 (*Fever – 100.0 F or greater; Chills; Shortness of breath or difficulty breathing; Fatigue; Muscle or body aches; Headache; New loss of taste or smell; Sore throat; Congestion or runny nose; Nausea or vomiting; Diarrhea; Coughing*)

☐ Tested positive through a diagnostic test for COVID-19.

☐ Knowingly been in close or proximate contact with anyone who has tested positive through a diagnostic test for COVID-19 or who has had symptoms of COVID-19.

☐ Traveled internationally or from a state with widespread community transmission of COVID-19 per the New York State Travel Advisory.

I attest that the above are true on this date.

Parent Signature: _____

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