Willsboro
CENTRAL SCHOOL DISTRICT

DAILY REQUIRED HEALTH SCREENING

1. *Since your last visit here, have you had any of these symptoms in the last 14 days? Symptoms of COVID-19 may include but are not limited to (refer to CDC for most recent information):*
    - *Cough*
    - *Shortness of breath or difficulty breathing*
    - *Fever or feeling feverish*
    - *Chills*
    - *Fatigue*
    - *Muscle/body pain*
    - *Headache*
    - *Sore throat*
    - *Congestion or runny nose*
    - *Nausea*
    - *Vomiting*
    - *New loss of taste or smell*
2. *Do you currently have a temperature over 100°F?*
3. *Have you tested positive for COVID-19 in the past 14 days?*
4. *Have you had any close contact in the last 14 days with someone with a confirmed or suspected COVID-19 case?*
5. *Have you traveled either internationally or outside of the state in the last 14 days? (following NYS guidance)*

*IF YOU HAVE ANSWERED **NO** TO ALL QUESTIONS, **YOU ARE SAFE TO ATTEND SCHOOL**.*

*IF YOU HAVE ANSWERED **YES** TO ANY OF THE QUESTIONS ABOVE, **DO NOT ATTEND SCHOOL** AND CONTACT THE SCHOOL NURSE TO SHARE THIS INFORMATION.*