Name: __________________ Grade _____ Date: ________

1) Have you been in close or proximate contact in the past 14 days with anyone who has tested positive through a diagnostic test for COVID-19 or who has or had symptoms of COVID-19? □ Yes □ No

2) Have you tested positive through a diagnostic test for COVID-19 in the past 14 days? □ Yes □ No

3) Have you 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? □ Yes □ No

4) Have you experienced any symptoms of COVID-19, including a temperature of greater than 100.0°F, in the past 14 days that you cannot attribute to another condition? □ Yes □ No

Signs and symptoms may include:
- Fever or chills
- Cough
- 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
- Muscles:
- Or difficulty breathing
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
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