ARLINGTON CENTRAL SCHOOL DISTRICT
COVID-19 SCREENING QUESTIONNAIRE

In order to prevent the spread of the COVID-19 and reduce the potential risk of exposure to our employees, we are asking everyone to complete and submit this questionnaire upon entering an Arlington building. Please respond to each of the following questions truthfully and to the best of your ability. Your participation is important to help us take precautionary measures to protect you and our other employees.

Name:       Today’s Date:

Phone Number (mobile/home):

Arlington Building:

1 Are you currently experiencing, or have you experienced in the past 10 days, any of the following symptoms? (Please take your temperature before you answer this question.)
   Yes ☐ No ☐ Fever (greater than 100° F)
   Yes ☐ No ☐ Cough
   Yes ☐ No ☐ Shortness of breath or difficulty breathing
   Yes ☐ No ☐ Sore throat
   Yes ☐ No ☐ New loss of taste or smell
   Yes ☐ No ☐ Chills
   Yes ☐ No ☐ Muscle or body aches or headache
   Yes ☐ No ☐ Fatigue
   Yes ☐ No ☐ Congestion or runny nose
   Yes ☐ No ☐ Nausea, vomiting or diarrhea

2 Have you been designated a contact (typically defined by 6 feet or closer for at least 10 minutes) of a person who is known to have a laboratory-confirmed positive COVID-19 test?
   Yes ☐ No ☐

3 Have you tested positive through a diagnostic test for COVID-19 in the past 10 days or are you waiting for results from a COVID-19 test?
   Yes ☐ No ☐

Certification

I hereby certify that the responses provided above are true and accurate to the best of my knowledge.

Signature: ___________________________    Date: ________________

Access to building (circle one):    Approved    Denied

Revised 5/5/21