

**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	<p>Are you currently experiencing, or have you experienced in the past 10 days, any of the following symptoms? <i>(Please take your temperature before you answer this question.)</i></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Fever (greater than 100° F)</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Cough</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Shortness of breath or difficulty breathing</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Sore throat</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> New loss of taste or smell</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Chills</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Muscle or body aches or headache</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Fatigue</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Congestion or runny nose</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Nausea, vomiting or diarrhea</p>
2	<p>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?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
3	<p>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?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
4	<p>Have you travelled outside of New York State (except for Vermont, Massachusetts, Connecticut, New Jersey or Pennsylvania) or internationally in the past 10 days? (Please see <a href="https://coronavirus.health.ny.gov/covid-19-travel-advisory">https://coronavirus.health.ny.gov/covid-19-travel-advisory</a> for the latest information.)</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>

**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