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 14 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 ☐ Head or muscle aches Yes ☐ No ☐ Fatigue Yes ☐ No ☐ Congestion or runny nose Yes ☐ No ☐ Headache
2	Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 10 minutes) with a person who is known to have laboratory-confirmed positive COVID-19 test or with anyone who has any symptoms consistent with COVID-19? Yes ☐ No ☐
3	Have you tested positive through a diagnostic test for COVID-19 in the past 14 days or are you waiting for results from a COVID-19 test? Yes ☐ No ☐
4	Have you travelled internationally or from a state with widespread community transmission of COVID -19 per the New York State Travel Advisory in the past 14 days (https://coronavirus.health.ny.gov/covid-19-travel-advisory)? 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 8/25/20