Bernards Township School District

COVID-19 Daily Screening Questionnaire for ESY/CST Evaluations

Student Form

Parents/Guardians of students must complete this form daily if they participate in a school sponsored activity.

Student Name: ___________________________Program: _______________Date: _________

I am aware that my child needs to provide and wear a **face covering/mask** upon arrival and whenever they are not able to socially distance. He/She must bring any of his/her own **labeled personal belongings** in a labeled bag, including **an extra face covering/mask**.

COVID-19 Questions:	**Please circle one**	
1. Has your child ever been diagnosed with Coronavirus (COVID-19)?	YES	NO
2. Has any member of the student's household been diagnosed with Coronavirus (COVID-19)?	YES	NO
3. Have you had close contact with someone who is sick?	YES	NO
4. Does your child currently have **any** of the following symptoms? If YES, **circle** which ones	YES	NO

Fever or Chills	Sore Throat
Cough	Congestion or Runny Nose
Shortness of Breath or Difficulty Breathing	Nausea, Vomiting or Diarrhea
Headache	Fatigue
New Loss of Taste or Smell	Muscle or Body Aches

To prevent the spread of COVID-19, the State of New Jersey has issued an incoming travel advisory that all individuals entering New Jersey from states with a significant spread of COVID-19 quarantine for 14-days after leaving that state. https://covid19.nj.gov/faqs/nj-information/general-public/are-there-travel-restrictions-to-or-from-new-jersey-should-i-self-quarantine-if-i-have-recently-traveled

5. Has your child traveled to any one of these states in the past 14 days?	YES	NO
6. Does your child have a **pre-existing medical condition** or is he/she immunocompromised?	YES	NO

Please be aware that the CDC lists these health conditions which may be associated with increased risk related to Covid-19 include, but are not limited to:
Lung Disease (Asthma, Bronchitis, COPD, Pulmonary Fibrosis, Cystic Fibrosis, Smoking); Autoimmune Disease or Immunocompromised (Cancer, Immune Deficiencies); Cardiovascular Disease (Heart Disease, Hypertension, Cerebrovascular Disease); Liver Disease; Kidney Disease; Diabetes; Neurologic Conditions; Hemoglobin Disorders (Sickle Cell Disease or Thalassemia) and Obesity.

*If you answered **YES** to any of the above COVID-19 questions, you must provide **written clearance** from a **medical doctor** to the School Nurse or during summer, Nursing Coordinator, Rita Zarabara rzarabara@bernardsboe.com before you can participate in any school or school sponsored activity.*

_______________________	_______________________	__________	__________
Signature of Parent/Guardian	Print Name	Date	Record Temperature if over 100.4 F **(Done by Screener)**