FRONTIER CENTRAL SCHOOL DISTRICT
Student COVID Screening Assessment Document

The following is a current list of COVID-19 symptoms that have been identified by the Center for Disease Control and Prevention (CDC):

- Fever
- 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

1. Have you experienced any COVID-19 related symptoms in the past 48 hours?
   ☐ **Yes** ☐ **No**
2. Have you tested positive for COVID-19 in the past 10 days?
   ☐ **Yes** ☐ **No**
3. Have you been in close contact with a confirmed or suspected COVID-19 case in the past 10 days?
   ☐ **Yes** ☐ **No**
4. Have you traveled to a Restricted State/Country as determined by NYS Covid-19 Travel Advisory in the last 10 days? The updated advisory may be found at https://coronavirus.health.ny.gov/covid-19-travel-advisory.
   ☐ **Yes** ☐ **No**

   If yes, have you had 2 negative COVID-19 tests or quarantined for 10 days as required by NYS?
   ☐ **Yes** ☐ **No**

Additionally, if your answer is Yes to items 1-3 of the above:

Your child should not attend school and you should contact your medical provider for guidance.

If you answered no to the above for your child, please let your child know if they begin to experience any of the symptoms while in school, they should immediately report to the nurses office.

Student Name: _____

Parent/Guardian Name: _____

Date: _____