Tully CSD Weekly Health Screening

Please send this completed form for each child once per week on or before Friday.

Student's Name _____ Grade _____

Does your child have a temperature of 100° F or above? Yes No

Has your child shown any COVID-19 symptoms today? Yes No
cough, shortness of breath, sore throat, chills, body aches,
headache, congestion, diarrhea, nausea, vomiting, loss of taste or smell

Does anyone in your home have any COVID-19 symptoms today? Yes No
See list above

Has your child and/or family traveled outside New York State in the past 14 days? Yes No

Has your child knowingly been near a person with COVID-19, with COVID-19 symptoms, waiting for COVID-19 test results or in quarantine? Yes No

_____ _____
Parent Signature Date

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