Port Jefferson School District
550 Scraggy Hill Rd.
Port Jefferson, NY 11777
631-791-4500

Daily Student Health Questionnaire

Student Name: _____ **Grade**: _____ **Date**: _____

Is your child currently experiencing any symptoms related to COVID-19? Symptoms include fever of 100 or higher, or at least two of the following symptoms: cough, shortness of breath, fever, chills, muscle pain, headache, sore throat, fatigue, new loss of taste or smell, loss of appetite, nausea, diarrhea.

In the past 14 calendar days has your child experienced any symptoms related to COVID-19?

Has your child tested positive for COVID-19 in the past 14 calendar days?

Has your child had close contact with an individual with a confirmed case of COVID-19 in the past 14 calendar days?

In the past 14 calendar days, has your child been requested/directed to self-quarantine or self-isolate by a medical professional or local public health official?

Has your child traveled within the past 14 calendar days, internationally or to a state with widespread community transmission of COVID-19 per the NEW YORK STATE TRAVEL ADVISORY. (see link: https://coronavirus.health.ny.gov/covid-19-travel-advisory)**?**

Check if your child is "Cleared" (No to all questions) or "Not Cleared" (Yes to any question)

_____Cleared _____Not Cleared

• If you answered "Not Cleared", please do not send your child to school.

• If you answered "Cleared " Please sign below

Parent/Guardian Name (please print): _____

Signature: _____ Date: _____