Daily BB-NYC Health Screening!

Circle Parent's Response. Any Yes response, child may not enter.

Student's Name:_____ Date:_____

1. Have you experienced a fever, a new cough, new loss of taste or smell, or shortness of breath within the past 10 days?
   1. No **2. Yes: Go Home**
2. In the past 10 days, have you tested positive for COVID-19 using a test that tested saliva or used a nose or throat swab (not a blood test)? (10 days measured from the date you were tested, not the date you received the test result.
   1. No **2. Yes: Go Home**
3. To the best of your knowledge, in the past 14 days, have you been in close contact (within 6 feet for at least 10 minutes) with anyone while they had COVID-19?
   1. No **2. Yes: Go Home**
4. In the past 14 days, have you traveled internationally or returned from a state that was identified by New York State as having widespread community transmission of COVID19 (other than just passing through the restricted state for less than 24 hours)?
   1. No **2. Yes: Go Home**

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