Weekly Health Questionnaire Grace Lutheran Church, Niagara Falls, NY

Date: ____________________________________

Student(s) Name(s): ____

1. Has your child or any member of your household tested positive for COVID-19 in the past 10 days? Yes No

2. In the last 14 days, has your family been in close contact (within 6 feet for ten minutes or more) with any person who has tested positive for COVID-19? Yes No

3. Has your child or household member traveled internationally or returned from a state identified by NYS as having widespread community transmission of COVID-19 in the last 14 days? Yes No

4. Is your child having COVID symptoms (fever of 100ºF or greater, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle of body ache, headache, new loss of taste or smell, sore throat, congestion, runny nose, nausea, vomiting, or diarrhea)? Yes No

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Parent/Legal Guardian Signature

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