NYSWDA COVID-19 Student Screening Checklist

Student Name: _____________________________________ Date: _____/_____/

Course: __________________________________________ Course Start Date: _____/_____/

1. Do you suspect or have any reason to believe that you or anyone in your home has COVID-19 currently or has had COVID-19 in the past 14 days?
   ☐ Yes
   ☐ No

2. Have you or anyone in your home been exposed to someone who has tested positive for COVID-19 in the past 14 days?
   ☐ Yes
   ☐ No

3. Have you or anyone in your household experienced any of the following in the past 14 days?
   ☐ Persistent fever
   ☐ Persistent cough
   ☐ Shortness of breath or difficulty breathing
   ☐ Chills including repeated shaking with chills
   ☐ Muscle pain
   ☐ Headache
   ☐ Sore throat
   ☐ New loss of taste or smell

By signing below, I affirm that all information provided is true and correct to the best of my knowledge.

___________________________________________
Signature

Please complete, sign, and scan this document to: rvisser@nyswda.org

Screening form must be received by NYSWDA prior to session start date.