Ballston Spa

CENTRAL SCHOOL DISTRICT

Wellness Screening Questionnaire

BSCSD Community Members – The following survey is required to be completed prior to entering any of our buildings. Please be aware a yes answer to any of the questions will prevent you from from entering our buildings.

1. Are you currently experiencing or have experienced new or worsening of the following symptoms in the past 14 days? (If you are experiencing any symptoms as part of a pre-existing health condition, please do not check Yes.)

a. Cough	◯ Yes	◯ No
b. Shortness of breath	◯ Yes	◯ No
c. Fever (100 F or above) or chills	◯ Yes	◯ No
d. Fatigue	◯ Yes	◯ No
e. Muscle or body aches	◯ Yes	◯ No
f. Headache	◯ Yes	◯ No
g. Sore throat	◯ Yes	◯ No
h. Loss of taste or smell	◯ Yes	◯ No
i. Nausea, stomach pain, vomiting or diarrhea	◯ Yes	◯ No
j. Congestion or runny nose	◯ Yes	◯ No

2. Have you been tested for COVID-19 in the past 14 days?
   ◯ Yes ◯ No

3. Are you currently waiting for COVID-19 test results? (If so, do not report to work)
   ◯ Yes ◯ No

4. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?
   ◯ Yes ◯ No

5. To the best of your knowledge, have you been in close proximity to any individual who tested positive for COVID-19 in the past 14 days?
   ◯ Yes ◯ No

6. Have you traveled to any of the states listed on the NYS Department of Health restricted travel list in the past 14 days? (Updated list is found at https://coronavirus.health.ny.gov/covid- 19-travel-advisory)
   ◯ Yes ◯ No

Date: Time:

Name:

Street:

City/Zip:

Phone: