Closster Public Schools

COVID-19 Visitor Screening Questionnaire

As part of our efforts to prevent the spread of the coronavirus and reduce the risk of potential exposure for you, our students and staff, you are required to complete this initial screening questionnaire and adhere to the following:

Please respond to each of the following initial questions truthfully and to the best of your ability.

1. Have you tested positive for COVID-19 and have you not been released from doctor's care? ☐ YES ☐ NO

2. Have you, either currently and/or within the past 14 days, been in close contact (within 6 feet for a cumulative total of 15 min. or more within 24 hrs.) to anyone who has tested positive? ☐ YES ☐ NO

3. In the past two weeks, has anyone in your household been diagnosed or been tested for Covid-19, or anyone in your household in contact with someone diagnosed with Covid-19? ☐ YES ☐ NO

4. Have you, either currently or in the past 14 days, experienced any two of the following symptoms that has not been attributed to a non-covid related condition?

- Fever or chills ☐ YES ☐ NO
- Cough ☐ YES ☐ NO
- Shortness of breath or difficulty breathing ☐ YES ☐ NO
- Fatigue ☐ YES ☐ NO
- Muscle or body aches ☐ YES ☐ NO
- Headache ☐ YES ☐ NO
- New loss of taste or smell ☐ YES ☐ NO
- Sore throat ☐ YES ☐ NO
- Congestion or runny nose ☐ YES ☐ NO
- Nausea or vomiting ☐ YES ☐ NO
- Diarrhea ☐ YES ☐ NO
- Blood clots or unexplained vascular issues, including unusual swelling of extremities ☐ YES ☐ NO

If you are unvaccinated, have you traveled outside the State of New Jersey within the past 14 days and did you travel to any of the states listed on the New Jersey travel advisory list found at *https://covid19.nj.gov/?* ☐ YES ☐ NO

Name ______________________ Signature ______________________ Date ______________

Phone Number ______________________