

WAJ Central School COVID-19 SCREENING DAILY ATTESTATION FORM

Faculty/Staff Student Visitor (please provide contact information)

I do hereby swear that the following statements are true for: _____

This information was gathered prior to entering a school building, campus, bus or vehicle. I understand that providing false statements may have severe consequences and may place others at risk for COVID-19. I promise not to attend or send my child(ren) to school with any illness or symptom of COVID-19. I will notify the school at 518-734-3400 ext. 1130 if my child is not attending school today or has symptoms of COVID-19.

In the past two weeks (14 days) have you experienced any symptoms of COVID19 such as a temperature of greater than 100.0°F, cough, shortness of breath or difficulty breathing, extreme tiredness (fatigue), muscle or body aches, headache, loss of taste or smell, sore throat, stuffy or runny nose, nausea or vomiting, and/or diarrhea?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you knowingly been in close or proximate contact in the past 14 days with anyone who has tested positive through a diagnostic test for COVID19 or who has or had symptoms of COVID19?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you tested positive through a diagnostic test for COVID19 in the past 14 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
SIGNATURE		Date:

* Please note: If you have any concerns regarding COVID-19 related to possible exposure, please contact our school nurse at ggonzalez@wajcs.org or via phone at 518-734-3400 ext. 1131.

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