GARFIELD PUBLIC SCHOOLS
34 OUTWATER LANE, GARFIELD, NEW JERSEY 07026-2693
973-340-5000 Ext 2300
FAX 973-340-4620 WWW.GBOE.ORG

Health Screening Questionnaire
Covid-19 Daily Screening Questions

If you answer "YES" to any screening question, or you recently tested positive for Covid-19 or are awaiting test results, you may have been exposed to the COVID-19 virus and must remain home as well as isolate/quarantine and contact your healthcare professional.

		Please Mark One	
1.	Are you experiencing any of the following symptoms?		
a.	Fever over 100.4* F or greater	Yes	No
b.	Cough or shortness of breath	Yes	No
c.	Sore throat	Yes	No
d.	Chills	Yes	No
e.	Muscle aches, shivering, or fatigue	Yes	No
f.	Headache	Yes	No
g.	Recent loss of taste or smell	Yes	No
h.	Abdominal pain, nausea, vomiting, or diarrhea	Yes	No
i.	Congestion or runny nose	Yes	No
j.	Difficulty breathing	Yes	No
2.	Have you/your child had close contact for at least 10 minutes within 6 ft of anyone who has been confirmed to be Covid-19 positive or someone who is currently sick?	Yes	No
3.	Have you/your child been diagnosed with Covid-19 in the past three weeks or have a reason to believe you have Covid-19?	Yes	No
4.	Have you/your child been tested for Covid-19 in the last 3 days?	Yes	No
	What was the result of your most recent COVID-19 test?	Awaiting results	Positive / Negative
5.	Have you/your child traveled to an area of high community transmission or to another country or another state within last 14 days? (see updated list of affected areas on the covid19.nj.gov website)	Yes	No
6.	If you/your child has been diagnosed with COVID-19, were you/your child symptomatic or hospitalized?	Yes	No

If you respond YES to one or more of the questions above, the student is not to report to school. Please contact the GHS Health Office for additional information. (973) 340-5010 x 2108 or x 2142