Greenville School

100 Glendale Road, Scarsdale, NY 10583

914-472-7760

COVID-19 Visitor Screening Questionnaire

Visitor's Name _____ Company Name: _____

Telephone No. _____

	YES	NO
Have you experienced any symptoms of COVID-19 in the past 14 days? ● Fever or chills (100 degrees F or greater) ● Cough ● Shortness of breath or difficulty breathing ● Fatigue ● Muscle or body aches ● Headache ● New loss of taste of smell ● Sore throat ● Congestion or runny nose ● Nausea or vomiting ● Diarrhea		
Have you knowingly been in close contact in the past 14 days with anyone who has tested positive through a diagnostic test for COVID-19 or who has had symptoms of COVID-19?		
Have you tested positive through a diagnostic test for COVID-19 in the past 14 days?		
Have you traveled internationally or from a state with widespread community transmission of COVID-19 per the New York State Travel Advisory in the past 14 days?		

DATE: _____ VISITOR SIGNATURE: _____