בס"ד

Hebrew School Health Screening Questionnaire

Please fill out the screening questionnaire each week and hand it to the Chabad Hebrew school staff upon arrival.

Student Name:

Parent/Gaurdian signature

Date:

Has this student had:

A temperature 100 degrees F or higher without the use of fever reducing medications?

☐ YES ☐ NO

A sore throat, congestion or runny nose not related to seasonal allergies?

☐ YES ☐ NO

A NEW uncontrolled cough (for students with chronic allergic asthmatic cough, a change in their cough from baseline)?

☐ YES ☐ NO

Difficulty breathing, diarrhea, vomiting or abdominal pain?

☐ YES ☐ NO

A NEW onset of severe headache, especially with fever?

☐ YES ☐ NO

Close contact (within 6 feet of an infected person for at least 15 minutes) with a personwith confirmed COVID-19 with or without a mask or have been in an area of high transmission of COVID-19 within the last 2 weeks?

☐ YES ☐ NO

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