

Great Valley School District Health Questionnaire

1. **Activity**

2. **Name**

3. **Yes-No** In the past 72 hours, have you or anyone in your household experienced symptoms of acute respiratory illness, such as: a fever of 99.5°F or higher, fatigue, body aches, cough, shortness of breath, sore throat, runny/stuffy nose, chills?

4. **Yes-No** In the past 14 days, have you had close contact (i.e. within 6 feet for more than a few minutes) with anyone who tested positive for COVID-19 (AKA coronavirus), is in the process of being tested for COVID-19, is isolating as a result of a suspected COVID-19 infection, or is experiencing acute symptoms of COVID-19?

5. **Yes-No** Have you recently traveled to any of the states currently listed on PA's List of Mandatory Quarantining?

<https://www.health.pa.gov/topics/disease/coronavirus/Pages/Travelers.aspx>

The questionnaire is also available by using the following QR code:

