

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**COVID-19 HEALTH SCREENING ATTESTATION**

The New York State Department of Health Interim Guidance for Child Care Programs requires all individuals to complete a daily health screening questionnaire before arriving to a child care program or upon arrival to a child care program.

If an individual answers "Yes" to any of the screening questions, they cannot enter the child care program, except as otherwise indicated.

**Screening Questions:**

1. Is your temperature higher than or equal to 100.4 degrees Fahrenheit?
2. Have you had any known close or proximate contact with a person confirmed (by diagnostic test) or suspected (based on symptoms) to have COVID-19 in the past 10 days? Note: Close contact is defined by DOH as being within 6 feet of an individual for 10 minutes or more within a 24-hour period, starting from 2 days before symptom onset or, if asymptomatic, 2 days before the date the positive sample was collected through when they are isolated. Close contact does not include individuals who work in a health care setting wearing appropriate, required personal protective equipment.

Exception: Asymptomatic staff and children may attend if the staff/child is fully vaccinated or has recovered from laboratory confirmed COVID-19 in the previous 3 months and has not been placed on quarantine. Note: Fully vaccinated is defined as being 2 weeks or more after either receipt of the second dose in a 2 dose vaccine series, or 2 weeks or more after receipt of one dose of a single-dose vaccine.

3. Are you currently experiencing or have you recently, (within the past 10 days) experienced ANY COVID-19 symptoms?

**Note:** Symptoms may occur with pre-existing medical conditions, such as allergies or migraines. You should only answer "Yes" if your symptoms are new or worsening.

- Cough
- Shortness of breath
- Trouble breathing
- Fever (equal to or above 100.4 degrees Fahrenheit)
- Chills
- Muscle pain or body aches
- Headache
- Sore throat
- Loss of taste or smell
- Fatigue
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

4. Have you tested positive for COVID-19 through a diagnostic test within the past 10 days?
5. Have you traveled within the past 10 days and not complied with requirements of the New York State Travel Advisory?

**Attestation:** I agree that I will self-monitor these symptoms each day, report the outcome to SETAUKET PRESBYTERIAN PRESCHOOL, and not enter SETAUKETPRESBYTERIAN PRESCHOOL if any of the above symptoms or conditions are present.

X  
\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

X  
\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Note:** This document must be signed and returned to the program prior to entry. A signed copy needs to be provided only once. The child care program must retain a copy for their records.