FALL SEASON – 1

Contest Assessment Form

Please check **YES** or **NO** for each question below	**YES**	**NO**
Do you have any of the following symptoms of COVID-19? - Temperature of 100°F or greater		
- Sore Throat		
- New uncontrolled cough that causes difficulty breathing (for students with chronic allergic/asthmatic cough, a change in their usual cough)		
- New loss of taste or smell		
- Diarrhea, vomiting, or abdominal pain		
- New onset of severe headache, especially with a fever		
In the last 14 days, have you:		
Traveled Internationally or outside NY State? - If **YES**, where did you go? _____ - When did you return? _____		
Been in close contact (within 6 feet of an infected person for at least 15 minutes) with a person with confirmed **COVID-19?**		
Been diagnosed with **COVID-19?**		
<u>If you marked **YES** to any of these questions, please do not enter the contest.</u> **Print Name:**_____ **Signature:**_____ **Telephone:**_____ **<u>Temperature:</u>** _____ **Thank you!**		