

Student Name: _____

Date: _____

Possible Symptoms of COVID 19:

Fever or chills

Muscle or body aches

Cough

Headache

Shortness of breath

New loss of taste or smell

Difficulty breathing

Sore throat

Fatigue

Congestion or runny nose

Nausea/Vomiting

Diarrhea

_____ **My child named above has cleared today's daily health check and does**
(Please check) **NOT have ANY symptoms of COVID 19 and does NOT have a**
fever of 100 °F or greater.

Parent Signature: _____

PLEASE NOTE: Any student with a fever of 100°F or greater **or** symptoms of possible COVID-19 virus infection **SHOULD NOT BE SENT TO SCHOOL!**

(please cut along the perforated line)

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1. Within the past 14 days, have you had contact with anyone that you know had COVID-19 or COVID-like symptoms? Contact is being 6 feet (2 meters) or closer for more than 15 minutes with a person, or having direct contact with fluids from a person with COVID-19 (for example, being coughed or sneezed on).

_____ YES

_____ NO

2. Have you had a positive COVID-19 test for active virus in the past 10 days?

_____ YES

_____ NO

3. Within the past 14 days, has a public health or medical professional told you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection?

_____ YES

_____ NO

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