Today's Date: ______________________________

Student's Name: _________________________

Please check if student has ANY of these symptoms. If ANY are checked, student may NOT attend in-person.

- ❑ **Has tested positive for COVID in the last 14 days**
- ❑ **Has been in close contact with someone who has tested positive for COVID in the last 14 days**
- ❑ **Fever or chills**
- ❑ **Cough**
- ❑ **New loss of taste or smell**
- ❑ **Shortness of breath/difficulty breathing**
- ❑ **Fatigue**
- ❑ **Muscle/body aches**
- ❑ **Headache**
- ❑ **Sore throat**
- ❑ **Nausea, vomiting, or diarrhea**

Temperature

Temp must not be over 100.0˚F

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Signature of parent/guardian or staff member

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