Please check if student has ANY of these symptoms. If ANY are checked, student may NOT attend in-person.			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.								
						<u> </u>	,		<ul> <li>☐ Has tested positive for COVID in the last 14 days</li> <li>☐ Has been in close contact with someone who has test positive for COVID in the last 14 days</li> </ul>		
							Fever or chills			-	+ uays
	Cough			rever or ermis							
	New loss of taste or smell	Temperature		Cough New loss of taste or smell							
	Shortness of breath/difficulty	remperature		Shortness of breath/difficulty	Temperature						
	breathing		_	breathing							
	Fatigue			Fatigue							
	Muscle/body aches			Muscle/body aches							
	Headache	Temp must not		Headache							
	Sore throat	Temp must not be over 100.0°F		Sore throat	Temp must not						
	Nausea, vomiting, or	be over 100.0 1		Nausea, vomiting, or	be over 100.0°F						
	diarrhea			diarrhea							
ignature	of parent/guardian or staff member		Signature	e of parent/guardian or staff member							
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