

**K-12 School COVID-19 Symptom Screening
Parent/Caregiver Attestation**

Child's First and Last Name: _____

Parent/Caregiver First and Last Name: _____

1. Has your child had close contact (within 6 feet for at least 15 minutes) in the last 14 days with someone diagnosed with COVID-19, or has any health department or health care provider been in contact with you and advised you to quarantine your child?

- Yes** Your child should not be at school. The child can return 14 days after the last time they had close contact with someone with COVID-19.
- No** Your child can be at school if they are not experiencing symptoms.

2. Does your child have any of these symptoms?

- | | |
|--|--|
| <input type="checkbox"/> Chills | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> New uncontrolled cough that causes difficulty breathing (for students with chronic allergic/asthmatic cough, a change in their cough from baseline); | <input type="checkbox"/> New headache |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> New loss of taste or smell |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Shortness of breath or difficulty breathing |
| | <input type="checkbox"/> Sore throat |
| | <input type="checkbox"/> Temperature of 100.4° or above |
| | <input type="checkbox"/> Vomiting |

*If a child has any of these symptoms, they should stay home, stay away from other people, and you should call their health care provider.

3. Since they were last at school, has your child been diagnosed with COVID-19?

- Yes** Your child should not be at school and should remain at home until they have met the *COVID-19 Return to School Guidelines*.
- No** Your child can be at school.

I attest that the following information is true to the best of my knowledge as of:

_____/_____/_____, ____:____ **AM PM** Signature: _____
MONTH DAY YEAR TIME CIRCLE ONE