Student's Daily Health Screening Attestation

Child's Name: ______________________________**Bus** ____

Parent/Guardian: ___________________________________

Has your child been in close contact (within 6 feet for at least 15 minutes) in the last 14 days with someone diagnosed with Covid-19 or been advised by a health professional to quarantine?

☐ Yes ☐ No

Does your child have any of these symptoms?

- ☐ Fever greater than 100.3
- ☐ Chills
- ☐ New cough
- ☐ New loss of taste or smell
- ☐ Shortness of breath or difficulty breathing

Has your child been diagnosed with Covid-19 since they last attended school?

☐ Yes ☐ No

I attest the above information is true to the best of my knowledge prior to my child attending school this day: ____ / ____ / ____

Parent Signature:

Student's Daily Health Screening Attestation

Child's Name: _______________________________ **Bus**____

Parent/Guardian: ___________________________________

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Parent Signature: