Student Name: ______________________________ Date: _______________

Possible Symptoms of COVID 19:

Fever or chills
Cough
Shortness of breath
Difficulty breathing
Fatigue
Nausea/Vomiting
Muscle or body aches
Headache
New loss of taste or smell
Sore throat
Congestion or runny nose
Diarrhea

__________ **My child named above has cleared today's daily health check and does NOT have ANY symptoms of COVID 19 and does NOT have a fever of 100 ℉ or greater.**

(Please check)

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)

Student Name: ______________________________ Date: _______________

Possible Symptoms of COVID 19:

Fever or chills
Cough
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New loss of taste or smell
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Diarrhea

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(Please check)

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!**

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

1. Within the past 10 days, have you had contact with anyone that you know had COVID-19 or COVID-like symptoms?.

   _____ YES _____NO

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

   _____ YES _____NO

3. Within the past 10 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

4. My child has not traveled to an area or state on the NYS quarantine list in the past ten days..

   _____ YES _____NO

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

(Please check)

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!**