|  |  |  |
| --- | --- | --- |
|  |  |  |
| *In the past 24 hours have you, your child or any other member of your household suffered from any of these symptoms?* |  |  |
| *In the past 14 days have you or your child had contact with a positive COVID 19 individual?* |  |  |
| *Temperature of 100 F or above?* |  |  |
| *Cough?* |  |  |
| Sore throat? |  |  |
| *Difficulty breathing?* |  |  |
| *Gastrointestinal symptoms (diarrhea, nausea, vomiting?* |  |  |
| *Unexplained rash?* |  |  |
| *Fatigue?* |  |  |
| *Headache?* |  |  |
| *New loss of taste or smell?* |  |  |
| New muscle aches? |  |  |
| Any other signs of illness? |  |  |

Child’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I attest that I am answering the above questions truthfully. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent signature /date

I attest that I am answering the above questions truthfully. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent signature /date

I attest that I am answering the above questions truthfully. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent signature /date

I attest that I am answering the above questions truthfully. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent signature /date

I attest that I am answering the above questions truthfully. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent signature /date