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?**

   ☐ Chills

   ☐ **New** uncontrolled cough that causes difficulty breathing (for students with chronic allergic/asthmatic cough, a change in their cough from baseline);

   ☐ Diarrhea

   ☐ Muscle pain

   ☐ Nausea

   ☐ New headache

   ☐ New loss of taste or smell

   ☐ Shortness of breath or difficulty breathing

   ☐ Sore throat

   ☐ Temperature of 100.4° or above

   ☐ 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