Student Name_____ Homeroom_____

I took my child's temperature today, _____.
(date)

Does your child have any of these symptoms that are not caused by another condition?

Fever or Chills	Fatigue	Sore throat
Cough	Muscle or body aches	Congestion
Shortness of breath or difficulty breathing	Headache	Nausea or vomiting
	Recent loss of taste or smell	Diarrhea

Within the past 14 days, has your child had contact with anyone that you know with COVID-19 or COVID-like symptoms?

Has your child or anyone in your home had a positive COVID-19 test for active virus in the past 10 days?

_____

My signature above verifies I took my child's temperature today and answer no to all questions.

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