



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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