DAILY REQUIRED HEALTH QUESTIONNAIRE Self Certification

Child's Name _____

Date_____ Time_____

Homeroom/1st period Teacher _____

Parent Signature _____

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1. Does your child have a Temperature of 100.4 or higher? Yes____ No ____
2. Has your child been in contact with a person with a positive covid-19 test in the last 48 hours? Yes____ No ____

Does your child have any of the following?	YES	NO
1. Fever	☐	☐
2. Shortness of breath	☐	☐
3. Cough	☐	☐
4. Chills	☐	☐
5. Repeated shaking with chills	☐	☐
6. Muscle pain	☐	☐
7. Headache	☐	☐
8. Sore Throat	☐	☐
9. New loss of taste or smell	☐	☐

If you answered YES to any of the above questions, your child must remain home and you must contact your building administrator.

If you do not return this form daily, your child will not be allowed to go to class until the form has been completed.