

By signing below, I confirm that my child was **symptom free and fever free** prior to that start of their school day.

Symptoms include:

Cough, Shortness of breath or difficulty breathing, Chills, Fatigue, Muscle or body aches, Congestion or runny nose, Sore throat, Headache, New loss of taste or smell, Nausea, Vomiting (unidentified cause, unrelated to anxiety or eating), Diarrhea

Child's First and Last Name: _____

<u>Date</u>	<u>Time</u>	<u>Parent/Caregivers Initials</u>
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

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