Date: Name:

Are you, your child or anyone in your household experiencing any NEW (within 24-48 hrs) or sudden symptoms of cough, shortness of breath or difficulty breathing, sore throat, loss of taste or smell, muscle aches, headache, fever or vomiting/diarrhea?).	◯ Yes ◯ No
Have you, your child or anyone in your household been in close proximity (6 feet for 10 minutes or more) of a person with confirmed COVID-19 in the last 14 days?	◯ Yes ◯ No
Have you, your child or anyone in your household been tested for COVID-19 and are waiting to receive test results? If yes, do NOT bring your child or children to school. Contact your school nurse or building principal immediately.	◯ Yes ◯ No
In the past 14 days, have you your child or anyone in your household been on a commercial flight, or traveled outside of the United States, or to any travel restricted state and remained there for greater than 48 hours?	◯ Yes ◯ No