## STUDENT Health Screening Attestation Form rev 2/1/2021

Student Name:				Date:		
-	lic Instr	uction	(OSPI) and Lo		_	
Symptoms	Yes	No	Symptom	s	Yes	No
A cough			Nausea/v	omiting		
Shortness of breath or difficulty breathing			Congestio	n/running nose (not related to seasonal allergies)		
Fever (100.4 or higher) or chills			Fatigue			
A sore throat			Headache			
Diarrhea			Has your	student been in close contact with anyone with confirmed COVID-19?		
Recent loss of taste or smell			you await *If your s	student had a positive COVID-19 test for active virus in the past 10 days, or are ing results of a COVID-19 test? Eudent is participating in the Peninsula SD Testing Program and is NOT action or a close contact, this question does NOT apply.		
Muscle or body aches				e past 14 days, has a public health or medical professional told your student to tor, self-isolate or self-quarantine because of concerns about COVID-19 infection?		
and the identified symptom(s) is not stay home or be sent home.	tattribu	ted to	another heal	and Local Health Authority, if the answer to any of the above questions is 'th condition as documented by the student's health care provider, your student's		nust
and the identified symptom(s) is not stay home or be sent home.  Signature of Individual Completing F  Student Name:  Parent/Guardian Name:  The Office of the Superintendent of Pub before entry to school each day. <b>Does y</b>	t attribu	STUD	ENT Health So	th condition as documented by the student's health care provider, your student's health care provider health care provi	dent r	
and the identified symptom(s) is not stay home or be sent home.  Signature of Individual Completing F  Student Name:  Parent/Guardian Name:  The Office of the Superintendent of Pub	t attribu	STUD	ENT Health So	th condition as documented by the student's health care provider, your student's health care provider, your students are not called the students and students undergo a health screen to call Health Authority requires that staff and students undergo a health screen to call health symptoms within the last day that are NOT caused by another	dent r	
and the identified symptom(s) is not stay home or be sent home.  Signature of Individual Completing F  Student Name:  Parent/Guardian Name:  The Office of the Superintendent of Pub before entry to school each day. Does y condition?	olic Instr	STUD  uction dent h	ENT Health So (OSPI) and Lo	th condition as documented by the student's health care provider, your student care provider, your students are provider.  Date:  Date:  Date: Local Health Authority requires that staff and students undergo a health screene following symptoms within the last day that are NOT caused by another staff.	dent r ening r	
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stay home or be sent home.

Signature of Individual Completing Form:\_\_\_