# Daily Health Attestation Form

Student's Name: ______________________________

Today's Date: ____________________

Current Time: ____________________

SYMPTOMS OBSERVED IN CHILD OR HOUSEHOLD MEMBER IN THE PAST 24 HOURS:

- ☐ Fever (100 degrees F or above), felt feverish or had chills?
- ☐ Cough?
- ☐ Sore throat?
- ☐ Rapid or difficulty breathing (without recent physical activity)?
- ☐ Gastrointestinal symptoms (diarrhea, nausea, vomiting)?
- ☐ Fatigue? (Fatigue alone should not exclude a child from participation)
- ☐ Headache?
- ☐ New loss of smell/taste?
- ☐ New muscle aches?
- ☐ Other signs of illness

WITHIN THE LAST 14 DAYS:

Have you or your family had close contact with a Covid-19 positive individual? No ☐ Yes ☐

Has your family traveled outside of MA and/or had close contact with someone from outside of MA? No ☐ Yes ☐

Please list where your child has been (excluding primary residence) since they were last in school:

______________________________________________________________________________

______________________________________________________________________________

Parent Signature:

____________________________________________________