NAME OF CHILD: ______________________ **DATE:** ______________________

BEST CONTACT NUMBER TODAY: ______________________

Daily Health Attestation

Please complete the following for each child. If you answer yes to any of the following, please do not bring the child to care.

SYMPTOMS OBSERVED IN CHILD OR HOUSEHOLD MEMBER IN THE PAST 24 HOURS?	YES	NO
Fever of 100.0° F or higher		
Cough		
Sore throat		
Rapid breathing 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		
Any other sign of illness		
WITHIN THE LAST 14 DAYS	**YES**	**NO**
Have you or your child had close contact with a COVID-19 positive individual?		

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

____

PARENT/GUARDIAN SIGNATURE: ______________________ **STAFF SIGNATURE:** ______________________

NAME OF CHILD: ______________________ **DATE:** ______________________

BEST CONTACT NUMBER TODAY: ______________________

Daily Health Attestation

Please complete the following for each child. If you answer yes to any of the following, please do not bring the child to care.

SYMPTOMS OBSERVED IN CHILD OR HOUSEHOLD MEMBER IN THE PAST 24 HOURS?	YES	NO
Fever of 100.0° F or higher		
Cough		
Sore throat		
Rapid breathing 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		
Any other sign of illness		
WITHIN THE LAST 14 DAYS	**YES**	**NO**
Have you or your child had close contact with a COVID-19 positive individual?		

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

____

PARENT/GUARDIAN SIGNATURE: ______________________ **STAFF SIGNATURE:** ______________________