NAME _____ **GRADE** _____

Check all the symptoms that the person had:

✓	**Symptoms**	**Must be Tested for- Covid19**
	Cough	Yes
	Shortness of breath or difficulty breathing	Yes
	New Loss of taste or smell	Yes
	Fever (temperature higher than 100.4 or felt feverish to the touch) or Chills	Yes, if two or more of these symptoms. No, if only one of these symptoms.
	Muscle or body aches	
	Headaches	
	Sore throat	
	Fatigue	
	Congestion or runny nose (new)	
	Nausea or vomiting	
	Diarrhea	

* If the test is negative, the student / person can return to school / child care / work when they have had no fever for 24 hours without the use of fever-reducing medication, and symptoms have improved (back to usual health). If the test is positive, the person must follow RIDOH isolation instructions.

Date symptoms started: _____ Date symptoms ended:_____

Student/Staff person had a COVID-19 test during this absence?

☐ No; if no; why not?: _____

☐ Yes; Date of test: _____ Test result:_____

Location of testing:_____

Isolation end date (if tested positive):_____

I attest that the student is ready to return to school and has:

☐ Not had a fever (temperature higher than 100.4) in the last 24 hours

☐ Not taken any fever-reducing medication in the last 24 hours

☐ Improved symptoms and is back to usual health

Name of person attesting: _____

(Parent/Guardian if minor)

Signature:_____ Date:_____