



RETURN TO SCHOOL FORM

Child's Name: _____

Date: _____

Dear School Family,

In an effort to minimize illness at school we ask that you check on the health of your child during your week(s) away from Park Shore Day School. Please have your child bring this completed form upon their return to school.

Please indicate any of the following symptoms:

- | | | |
|------------------------------|-----|----|
| • Cough | YES | NO |
| • Short of breath | YES | NO |
| • Fever | YES | NO |
| • Chills | YES | NO |
| • Muscle Pain | YES | NO |
| • Sore Throat | YES | NO |
| • New loss of taste or smell | YES | NO |
| • Nausea | YES | NO |
| • Vomiting | YES | NO |
| • Diarrhea | YES | NO |

1. My child has not been around anyone with any of the listed symptoms or diagnosis of COVID-19. Initial _____
2. No one in our household has been sick. Initial _____
3. My child has not traveled by air or traveled out of state. Initial _____
4. My child has adhered to our state's guidelines regarding COVID-19. Initial. _____

My signature indicates that I have completed this to the best of my ability. We understand that arriving to school healthy is vital to a health school for all.

Parent/Guardian Signature: _____ Date: _____