COVID-19 Employee and Student Wellness Self-Assessment RETURN to SCHOOL Form

Date: ____________

Employee or Student Name (please print): ___________________________________

School Name: ___________________________________________

I, _______________________, attest to the following:

- I have had no fever for at least three days without taking medication to reduce fever during that time.
- Date of last fever of 100 degrees or higher: _____________________
- My respiratory symptoms (cough and shortness of breath) have improved.
- Date respiratory symptoms began improving: ______________
- At least ten days have passed since my fever and/or respiratory symptoms began.
- Date fever and/or respiratory symptoms began: _____________________
- I had a positive COVID-19 test (with or without symptoms) on ________________.

Note: An employee or student may return after 10 days have passed from the date of the positive result.

Employee or Student Signature: ______________________________________

Today’s Date: ____________

Date Expected to Return to School: ____________

Superintendent’s or His/Her Designee’s Acknowledgment of Receipt of Form:

Signature: ______________________________________

Date: ____________________________