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: _____