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 IN THE PAST 24 HOURS?	YES	NO
Fever (100 .0° and higher), feverish, had chills		
Cough		
Sore throat		
Difficulty breathing		
Gastrointestinal distress (nausea, vomiting, or diarrhea)		
New loss of taste or smell		
New muscle aches		
Fatigue *must be in combination with other symptoms to be cause for exclusion*		
Headache *must be in combination with other symptoms to be cause for exclusion*		
Runny nose or congestion *must be in combination with other symptoms to be cause for exclusion*		
Any other signs of illness *must be in combination with other symptoms to be cause for exclusion*		
WITHIN THE LAST 14 DAYS	**YES**	**NO**
Has 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

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WITHIN THE LAST 14 DAYS	**YES**	**NO**
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