2021-22 HEALTH CLEARANCE FORM

Student Name:_____

Staff Name: _____

Parent/Caretaker: _____

Visitor:_____

Do you have any of the following symptoms:

- Fever of over 100.4
- Cough (newly developed)
- Shortness of breath or difficulty breathing
- Fatigue and/or muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose

Been in close contact with anyone who has had symptoms of Covid 19 (any of the above)

Been in close contact with anyone who has tested positive for Covid 19 in past 7 days

Tested positive for Covid 19 in the past 7 days

No_____Yes_____

If you answered Yes to any of the above, you may not enter the building

Signature_____Date_____