

SEAFORD SCHOOL DISTRICT HEALTH SCREENING TICKET

COVID-19 Health Screening

Student Name: _____

Grade: _____

- I took my child's temperature today and it was less than 100.0° F.
- My child does not have any COVID-19 symptoms: sore throat, new uncontrolled cough, chills, diarrhea, vomiting or abdominal pains.
- My child has not tested positive for COVID-19 in the last 14 days.
- My child has not had close contact (within 6 feet of an infected person for at least 15 minutes) with a person with confirmed or suspected COVID-19 within the last 14 days.
- My child has not traveled to a high infection area in the last 14 days.

PLEASE NOTE: BY SIGNING THIS TICKET, I ATTEST THAT THE INFORMATION INDICATED ABOVE IS TRUE AND ACCURATE.

Parent Signature: _____

Date: _____

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- My child has not tested positive for COVID-1 in the last 14 days.
- My child has not had close contact (within 6 feet of an infected person for at least 15 minutes) with a person with confirmed or suspected COVID-19 within the last 14 days.
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