

SAINT PHILIP SCHOOL MONITOR-TO-STAY ATTESTATION FORM






DAY 1

DAY 2

DAY 3

DAY 4

DAY 5

				
<p>I attest that my child,</p> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <p>has none of the following symptoms. (Please check all of the below to ensure that your child is not experiencing any of the common symptoms.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> No headache <input type="checkbox"/> No shortness of breath <input type="checkbox"/> No difficulty breathing <input type="checkbox"/> No diarrhea <input type="checkbox"/> No vomiting <input type="checkbox"/> No fever <input type="checkbox"/> No chills <input type="checkbox"/> No runny nose <input type="checkbox"/> No congestion <input type="checkbox"/> No sore throat <input type="checkbox"/> No cough <input type="checkbox"/> No fatigue <input type="checkbox"/> No muscle or body aches <input type="checkbox"/> No loss of taste <input type="checkbox"/> No loss of smell <p>Date: _____</p> <p>Parent Signature:</p> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>	<p>I attest that my child,</p> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <p>has none of the following symptoms. (Please check all of the below to ensure that your child is not experiencing any of the common symptoms.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> No headache <input type="checkbox"/> No shortness of breath <input type="checkbox"/> No difficulty breathing <input type="checkbox"/> No diarrhea <input type="checkbox"/> No vomiting <input type="checkbox"/> No fever <input type="checkbox"/> No chills <input type="checkbox"/> No runny nose <input type="checkbox"/> No congestion <input type="checkbox"/> No sore throat <input type="checkbox"/> No cough <input type="checkbox"/> No fatigue <input type="checkbox"/> No muscle or body aches <input type="checkbox"/> No loss of taste <input type="checkbox"/> No loss of smell <p>Date: _____</p> <p>Parent Signature:</p> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>	<p>I attest that my child,</p> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <p>has none of the following symptoms. (Please check all of the below to ensure that your child is not experiencing any of the common symptoms.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> No headache <input type="checkbox"/> No shortness of breath <input type="checkbox"/> No difficulty breathing <input type="checkbox"/> No diarrhea <input type="checkbox"/> No vomiting <input type="checkbox"/> No fever <input type="checkbox"/> No chills <input type="checkbox"/> No runny nose <input type="checkbox"/> No congestion <input type="checkbox"/> No sore throat <input type="checkbox"/> No cough <input type="checkbox"/> No fatigue <input type="checkbox"/> No muscle or body aches <input type="checkbox"/> No loss of taste <input type="checkbox"/> No loss of smell <p>Date: _____</p> <p>Parent Signature:</p> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>	<p>I attest that my child,</p> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <p>has none of the following symptoms. (Please check all of the below to ensure that your child is not experiencing any of the common symptoms.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> No headache <input type="checkbox"/> No shortness of breath <input type="checkbox"/> No difficulty breathing <input type="checkbox"/> No diarrhea <input type="checkbox"/> No vomiting <input type="checkbox"/> No fever <input type="checkbox"/> No chills <input type="checkbox"/> No runny nose <input type="checkbox"/> No congestion <input type="checkbox"/> No sore throat <input type="checkbox"/> No cough <input type="checkbox"/> No fatigue <input type="checkbox"/> No muscle or body aches <input type="checkbox"/> No loss of taste <input type="checkbox"/> No loss of smell <p>Date: _____</p> <p>Parent Signature:</p> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>	<p>I attest that my child,</p> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <p>has none of the following symptoms. (Please check all of the below to ensure that your child is not experiencing any of the common symptoms.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> No headache <input type="checkbox"/> No shortness of breath <input type="checkbox"/> No difficulty breathing <input type="checkbox"/> No diarrhea <input type="checkbox"/> No vomiting <input type="checkbox"/> No fever <input type="checkbox"/> No chills <input type="checkbox"/> No runny nose <input type="checkbox"/> No congestion <input type="checkbox"/> No sore throat <input type="checkbox"/> No cough <input type="checkbox"/> No fatigue <input type="checkbox"/> No muscle or body aches <input type="checkbox"/> No loss of taste <input type="checkbox"/> No loss of smell <p>Date: _____</p> <p>Parent Signature:</p> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>