DAILY SYMPTOM CHECKLIST

NAME: ____

NAME: ____

NAME: ____

NAME: ____

I verify that today (date) __________________________ the above-listed students do not have any of the following symptoms:

- ■ Fever of 100.4
- ■ Chills
- ■ Shortness of breath/difficulty breathing
- ■ Fatigue, muscle or body ache
- ■ Headache
- ■ Loss of taste or smell
- ■ Sore throat
- ■ Congestion/runny nose
- ■ Nausea, vomiting, diarrhea

PARENT SIGNATURE: _________________________________