



COVID-19 ATTESTATION FORM

NAME

/ /
DATE

By signing below, I verify that today — and in the past 24 hours — my child/I (if staff member) have not had any of the following symptoms:

- Fever (100° F or higher), feverish, had chills
- Unexplained sore throat
- Fatigue, when in combination with other symptoms
- New loss of taste or smell
- Headache, when in combination with other symptoms
- Cough, not due to other known cause
- Nausea, vomiting or diarrhea
- Shortness of breath/difficulty breathing
- Congestion or runny nose (not due to other known causes, such as allergies), when in combination with other symptoms
- Unexplained muscle or body aches
- Any other sign of illness in conjunction with any of the above

NEXT STEPS

Any individual who answered “yes” to any of the above questions, STOP! Do not come to First Circle. Your child/you (if staff member) must stay home until symptom-free without the use of medication for 24 hours.

ATTESTATION

YES In the past 14 days, my child has not had close contact with a person
NO known to be infected with COVID-19.

YES My child has not been given any medication today that could mask a fever.
NO

YES No one in my household is awaiting results from a COVID test.
NO

YES I have adhered to the Massachusetts travel guidelines.
NO

SIGNED