

Return to Athletics

COVID-19 Parent Attestation Form

STUDENT INFORMATION

First name

Last name

Birth date

Gender at Birth

COVID19 Positive Test Date

School Name

Grade (2021/2022 school year)

PARENT/GUARDIAN INFORMATION

First name

Last name

Relationship

Cell Phone

Home Phone

Email

After testing positive for COVID-19 has your child experienced:

| | | |
|---|-----|----|
| Excessive shortness of breath? | YES | NO |
| Chest pains? | YES | NO |
| Palpitations (fluttering of heart)? | YES | NO |
| Syncope (dizziness, fainting or light headiness)? | YES | NO |

Was your child hospitalized? YES NO

Did your child experience fevers greater than 100.4 degrees for more than 4 days or a fever higher than 103 degrees at any time? YES NO

Submission

I certify, by my electronic signature below, that the above submitted information is accurate and complete.

Electronic signature* (*Type your name*)

Signatory must be child's legal parent or guardian

Please Note - Please note, upon review of this form you may be contacted as further medical clearance from your child's physician may be required.