 **COVID-19 QUESTIONNAIRE & ATTESTMENT**

**This form is now a required document that all families must fill out and return PRIOR to the return to school and/or when there is a period that you have been out of school.** **(absences, vacation, visits with family or friends from out-of-state and/or interisland) Please answer honestly and truthfully as this situation effects and could potentially affect all of us and our ability to continue to provide this service to you. (We will send this home prior to such period as per our jurisdiction.)**

Have you/your child experienced any of the following symptoms in the past 48 hours?

* Fever or chills
* Cough
* Sore throat
* Congestion of Runny Nose
* Shortness of breath or difficulty breathing
* Muscle or body aches
* Headache
* New loss of taste or smell
* Nausea, vomiting, or diarrhea

**Answer**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Within the past 14 days, have you been in close physical contact (6 feet or closer for a cumulative total of 15 minutes) with:

* Anyone who is known to have **laboratory confirmed** COVID-19? **OR**
* Anyone who has exhibited symptoms consistent with COVID-19?

**Answer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19? **Answer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Are you currently waiting on the results of a COVID-19 test? **Answer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Have you had a positive COVID-19 test in the past 10 days? **Answer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Have you travelled/come into contact with someone that has travelled outside the State of Hawaii within the past 14 days? **Answer: \_\_\_\_\_\_\_ If** **YES,** when, and where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*\*

**\*\*(Child is REQUIRED to get screened for COVID-19 from state-approved laboratory to return to school)**

Have you travelled interisland within the past 14 days? **Answer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If **YES,** when, and where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (***Applicable Quarantine/Negative Covid-19 test required to return to school.)***

**This form is applicable in addition to ALL previous preschool-issued notices & guidelines pertaining to COVID-19. My signature below hereby attests that I have truthfully and honestly answered ALL the above questions. Failure to do so will result in my child being denied access to enter the preschool until form is returned. \*\*\*EMAILING TO THE PRESCHOOL IS PREFERRED\*\*\***

**Childs Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SWPS.Covid-19doc/12.2020 PARENT SIGNATURE AND DATE**