LPHS PARENT SELF-CERTIFICATION FORM

ALL STUDENTS MUST WEAR A MASK EACH DAY.

DATE_____

STUDENT NAME(S)

PARENT SIGNATURE: *I certify that I have checked my child(ren) today and they are not exhibiting any of the COVID-19 symptoms below nor have they tested positive or recently been exposed to someone who has tested positive for COVID-19 to my knowledge.*

COUGH	**CHILLS**	**LOSS OF TASTE OR SMELL**
SHORTNESS OF BREATH	**MUSCLE/BODY ACHES**	**VOMITING/DIARRHEA**
DIFFICULTY BREATHING	**FEVER (ABOVE 100.4°)**	

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