Participant/Guardian Self-Health Certification

Name: _____

I certify that the above named is free of fever or signs of illness.

Please check:

- ☐ No temperature of 100° F or above in the last 24 hours.
- ☐ No communicable illness symptoms (fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste of smell, sore throat, vomiting, and/or diarrhea).
- ☐ Has not been in close contact with a person who has or is suspected to have COVID-19 within the past 14 days.

Signature: _____ Date: _____