



BRISTOL-BURLINGTON HEALTH DISTRICT
240 Stafford Avenue, Bristol, Connecticut 06010-4617
Tel. (860) 584-7682 • Fax (860) 584-3814 • www.bbhd.org



DAILY COVID-19 ASSESSMENT

**Prior to your child attending school,
complete the following and submit to your child's school**

Child's Name: _____ Grade: _____

If you check any of the following DO NOT send your child to school

- My child has a fever (an elevated body temperature) of 100 degrees F. or above *
- My child is experiencing difficulty breathing and/or shortness of breath *
- My child has a persistent cough (is constantly coughing) *
- My child has a loss of taste and/or smell *
- My child was diagnosed with (or tested positive for) COVID-19 within the last 14 days **
- My child is/was a close contact of a COVID-19 positive individual within the last 14 days **
- My child spent at least 24 hours in a state listed on CT's COVID-19 Travel Advisory within the last 14 days **

*** A signed note from a CT Licensed Physician, APRN, Physician Assistant, or Nurse Practitioner, identifying they have assessed your child, the date of assessment, and that they have cleared your child to return to school, must be received by the school nurse prior to your child returning to school.**

**** For COVID-19 specific criteria, the School Nurse or the Public Health Authority will approve your child's return to school.**