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BOARD OF EDUCATION: Donald L. Bridge • Andrew Cruz • Christina Gagnier • James Na • Joe Schaffer • SUPERINTENDENT: Norm Enfield, Ed.D.

Positive COVID-19 Student Attestation Form To Return to School

Student Name: _____ School: _____

Date of Birth: ____/____/____ Grade: _____

Select location test was taken

- Medical Care Provider / Lab
- Home

Date of 5th day of Isolation: ____/____/____
Isolation starts on the first day of symptom(s) or the positive test collection date, whichever occurs first.

Date test was taken: ____/____/____
Test must be on day 5 or later from the start of isolation (see above for Day 5).

Select Test Type

- FDA Approved Antigen Diagnostic Test
- PCR diagnostic test / pooled PCR

Test Result

By checking this box, I attest that my child received a negative test result on the 5th day of isolation or later.

By checking this box, I attest that my child has been fever free without fever reducing medication for 24 hours.

By checking this box, I attest that any COVID-19 like symptom(s) have improved. *Symptoms include headache, runny nose, congestion, nausea, vomiting, diarrhea, muscle/body aches, fatigue, persistent/uncontrolled cough, difficulty breathing.*

Note: Taste and smell do not need to improve for a return to school.

Parent/Guardian Name & Signature

_____/____/____
Date

**Return this completed Positive COVID-19 Student Attestation Form
to the school/attendance office upon return to school.**