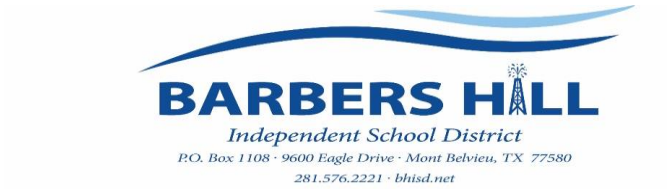


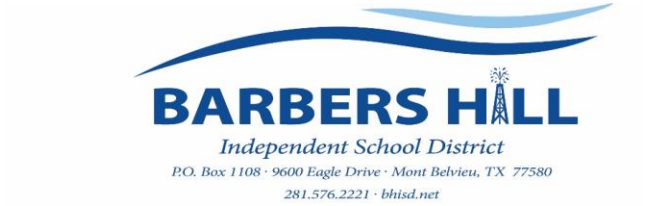
BHISD COVID-19 QUARANTINE RETURN FORM (OPTIONS 1 & 2 ONLY)

I affirm that my child _____ has not exhibited any of the following COVID-19 symptoms any time during the quarantine.

Symptoms include: *fever equal to or greater than 100° F, chills/muscle aches, headache (new onset or severe), diarrhea, new cough, shortness of breath/difficult breathing, loss of taste or smell, sore throat, unusual fatigue, congestion or runny nose, nausea/vomiting/abdominal pain.*

I understand that by selecting a 7 or 10 day quarantine, my child must wear a mask as well as self-monitor through day 14.

Parent Signature: _____Date:_____



BHISD COVID-19 QUARANTINE RETURN FORM (OPTIONS 1 & 2 ONLY)

I affirm that my child _____ has not exhibited any of the following COVID-19 symptoms any time during the quarantine.

Symptoms include: *fever equal to or greater than 100° F, chills/muscle aches, headache (new onset or severe), diarrhea, new cough, shortness of breath/difficult breathing, loss of taste or smell, sore throat, unusual fatigue, congestion or runny nose, nausea/vomiting/abdominal pain.*

I understand that by selecting a 7 or 10 day quarantine, my child must wear a mask as well as self-monitor through day 14.

Parent Signature: _____Date:_____