COVID-19 MEDICAL CLEARANCE DECLARATION FORM

I,____(your name):

(Check one of the following to describe your relationship to the school)

☐ *Parent/guardian of student(s)______________________________________(student's name)*

☐ *Employee of Light of Christ Catholic Schools*

☐ *Substitute or Intern/Practicum*

☐ *Student*

☐ *Volunteer or person from outside agency*

Hereby confirm that I have been: ☐ *and/or my child has been:* ☐

☐ *COVID-19 symptom free for 48 hours*

☐ *Not required, or no longer required, by Public Health to self-isolate*

As of ____________________________________ (date)

____ _________________________

Signature *Date of Signing*