Kirby School District 140

Self-Certification Process

- On the first day of the second quarter, parents need to fill out and sign this certification form prior to sending their Hybrid students to school. Once at school, students will be given a certification booklet to use on subsequent days. This form will be posted on our website if you need a copy.
- The form will be collected by the first point of District contact, (i.e. bus driver, teacher, or paraeducator) at entrance to the school, etc.
- If the student does not have a form, or if the form is not filled out properly or completely by a bus rider, the student will be seated at the front of the bus and held once the bus reaches school. The student will then be escorted off the bus by a staff member and taken to a check-in station, where their temperature will be taken, and the student's parents will be contacted to verify student status.
- Walkers and car riders will also be asked for their certification form at the first point of contact. If the student does not have a form, or if the form is not filled out properly or completely, the student will be taken to a check-in station, where their temperature will be taken, and the student's parents will be contacted to verify student status.
- Students whose parents cannot be reached will be isolated until a parent or emergency contact can be reached.

ksd140.org

STUDENT'S NAME: ______________________

PARENT CONTACT NUMBER: ______________________

DATE: ______________________

Self Certification Questions

Did you take your child's temperature in the past 24 hours?

☐ Yes ☐ No

If yes, please write your child's last known temperature ________

Please check if your child has taken any of these medications in the past 24 hours?

☐ Acetaminophen ☐ Tylenol ☐ Ibuprofen ☐ Advil ☐ Motrin

Please select the symptoms that your child has had in the past 24 hours:

☐ Fever ☐ Cough ☐ Shortness of breath ☐ Chills
☐ Difficulty breathing ☐ Fatigue ☐ Muscle and body aches
☐ Headache ☐ Sore throat ☐ New loss of taste or smell
☐ Congestion ☐ Runny nose (unrelated to seasonal allergies)
☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ None of the above.

If your child or any member of the household has left the state/ country overnight within the last 14 days, please list the state or country visited:

____

Has your child been exposed to or in contact with someone who has tested positive for COVID-19 or has COVID-19 like symptoms?

☐ Yes ☐ No

Is your child or any member of the household currently awaiting the results of a COVID-19 test?

☐ Yes ☐ No

Parent/Guardian Signature: ______________________

اسم الطالب : ______________________________

رقم اتصال ولي الأمر : __________________________

تاريخ : ____________________

أسئلة الشهادة الذاتية

هل قمت بقياس درجة حرارة طفلك خلال الـ 24 ساعة الماضية؟

☐ لا ☐ نعم

إذا كانت الإجابة بنعم ، يرجى كتابة آخر درجة حرارة معروفة لطفلك ______

يرجى التحقق مما إذا كان طفلك قد تناول أيًا من هذه الأدوية خلال الـ 24 ساعة الماضية؟

Acetaminophen, Tylenol, Ibuprofen, Advil, Motrin

أسيتامينوفين ، تايلينول ، إيبوروبفين ، أدفيل ، موترين

يرجى تحديد الأعراض التي عانى منها طفلك خلال الـ 24 ساعة الماضية

Fever	حمى
Cough	سعال
Shortness of Breath	ضيق في التنفس
Chills	قشعريرة
Difficulty breathing	صعوبة في التنفس
Fatigue	إعياء
Muscle and body aches	آلام في العضلات والجسم
Headache	صداع الراس
Sore throat	إلتهاب الحلق
New loss of taste or smell	فقدان جديد للطعم والرائحة
Congestion	ازدحام، اكتظاظ، احتقان
Runny nose-	سيلان الأنف -
(unrelated to seasonal allergies)	(غير مرتبط بالحساسية الموسمية)
Nausea	غثيان
Vomiting	التقيؤ
Diarrhea	إسهال
None of the above	لا شيء مما بالأعلى

إذا غادر طفلك أو أي فرد من أفراد الأسرة الولاية / الدولة خلال آخر 14 يومًا ، فيرجى كتابة الولايات أو الدولة التي تمت زيارتها

أو ظهرت عليه أعراض مشابهة لأعراض COVID-19 هل تعرض طفلك أو كان على اتصال بشخص ثبتت إصابته بفيروس

☐ لا ☐ نعم

هل طفلك أو أي فرد من أفراد الأسرة ينتظر حاليًا نتائج اختبار COVID-19؟

☐ لا ☐ نعم

يرجى التوقيع على نموذج اللغة الإنجليزية في أي مكان على الصفحة ، وإعادته إلى المدرسة

STUDENT'S NAME: ______________________________

PARENT CONTACT NUMBER: ______________________

DATE: ____________________

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☐ Yes ☐ No

Parent/Guardian Signature: ______________________________

NOMBRE DE ESTUDIANTE____
NUMERO DE CONTACTO DE PADRES__________________________________
FECHA_________________

Preguntas de Auto Certificacion

Le a tomado la temperatura a su hijo(a) en las ultimas 24 horas?
SI___ NO___
Si marco SI, favor de escribir la ultima temperatura __________

Por favor de marcar si su hijo(a) a tomado uno de estos medicamentos en las ultimas 24 horas?
___Acetaminophen ___Tylenol ___Iburofen ___Advil ___Motrin

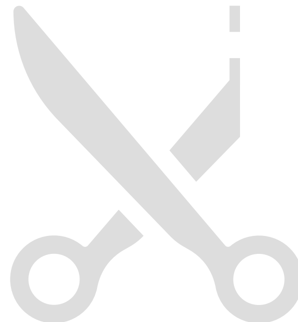
Por favor seleccione los sintomas que su hijo(a) a tenido en las ultimas 24 horas:
___Fiebre ___Tos ___Falta de aire ___Escalofrios
___Dificultad para respirar ___Fatiga ___Dolores de cuerpo y musculos
___Dolor de cabeza ___Dolor de garganta ___Perdida de olfato o sabor
___Congestion ___Nariz que moquea (que no sea por alergias)
___Nausea ___Vomitos ___Diarrhea ___Ninguno de estos sintomas

Si su hijo(a) o algun miembro de su casa a salido o a pasado la noche fuera del estado/pais en los ultimos 14 dias, por favor de apuntar el nombre del estado o pais que fue visitado:

____

A estado su hijo(a) expuesto o a tenido contacto con alquien que a sido positivo al COVID-19 o tiene sintomas?
___SI ___NO

Esta su hijo(a) o algun miembro de su casa actualmente esperando resultados de la prueba del COVID-19?
___SI ___NO



STUDENT'S NAME: ______________________________
PARENT CONTACT NUMBER: ______________________
DATE: ____________________

Self Certification Questions

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☐ Yes ☐ No

Is your child or any member of the household currently awaiting the results of a COVID-19 test?
☐ Yes ☐ No

Parent/Guardian Signature: ______________________________

IMIĘ I NAZWISKO UCZNIA: ______________________________
NUMER KONTAKTOWY RODZICÓW: ______________________
DATA: ______________________

Pytania dotyczące samodzielnej weryfikacji

Czy w ciągu ostatnich 24 godzin zmierzyłeś temperaturę dziecka?
___ Tak ___ Nie
Jeśli tak, proszę wpisać ostatnią znaną temperaturę dziecka __________

Proszę sprawdzić, czy dziecko brało któryś z tych leków w ciągu ostatnich 24 godzin?
___ Acetaminophen (paracetamol) ___ Tylenol ___ Ibuprofen ___Advil ___ Motrin

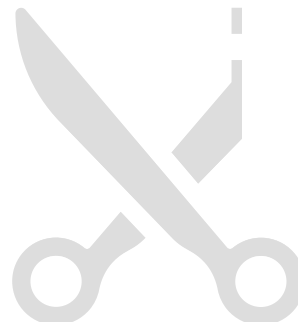
Proszę wybrać objawy, które dziecko miało w ciągu ostatnich 24 godzin:
___Gorączka ___Kaszel ___Duszności ___Dreszcze
___Trudności w oddychaniu ___Zmęczenie ___Bóle mięśni i ciała
___Bóle głowy ___Bóle gardła ___Nowe objawy utraty smaku i zapachu
___Zatory ___Katar (nie związany z sezonowymi alergiami)
___Mdłości ___Wymioty ___Biegunka ___Żadne z powyższych.

Jeśli dziecko lub któryś z członków gospodarstwa domowego opuścił stan/państwo w ciągu ostatnich 14 dni, proszę wymienić stan/państwo odwiedzane:

____

Czy Twoje dziecko było narażone lub miało kontakt z kimś, kto miał pozytywny wynik testu na COVID-19 lub ma objawy podobne do COVID-19?
___Tak ___Nie

Czy Twoje dziecko lub którys z członków gospodarstwa domowego oczekuje obecnie na wyniki badania COVID-19?
___Tak ___Nie



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