COVID-19 FACILITY USE ATTESTATION PLAN

The Issaquah School District requires that all groups entering our facilities must disclose an attestation plan before a reservation is made.

Briefly describe your attestation plan. A plan should include how you will distribute attestations to participants, what criteria you will use to determine who is eligible to be in our facility and how you plan to retain the documentation.

For each scheduled use, please keep a list of participants.

Should a positive COVID test result occur, groups must notify the Issaquah School District immediately and be able to provide a list of attendees along with a screening form for all members who have been in our building(s) on any given date.

Attached is a sample Screening Form for your use to screen participants and/or volunteers. If your organization has their own screening form, feel free to use that.

By signing below, the party acknowledges that they have read and agree to the foregoing subsection.

User’s authorized representative          Date

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SAMPLE - Health Attestation Form

Student Name: ___________________________

Per the State of Washington's Reopening Guide, __________ is asking participants to "self-certify that they have experienced no COVID-19 symptoms. This requirement serves the purpose of ensuring that all community members remain vigilant of their health in order to avoid the possible transmission of COVID-19 onto our campus.

1. In the last 14 days, have you experienced any of the following symptoms?
   a. A new fever (100.4 F or higher) or a sense of having a fever?
   b. A new cough that you cannot attribute to another health condition?
   c. New shortness of breath that you cannot attribute to another health condition?
   
   _____ YES  _____ NO

2. In the last 14 days, have you experienced any "two" of the following symptoms?
   a. A new sore throat that you cannot attribute to another health condition?
   b. New muscle aches that you cannot attribute to another health condition or that may have been caused by a specific activity, such as physical exercise?
   c. New respiratory symptoms, such as sore throat, runny nose/nasal congestion or sneezing, that you cannot attribute to another health condition?
   d. New chills or repeated shaking with chills that you cannot attribute to another health condition?
   e. New loss of appetite, diarrhea or vomiting that you cannot attribute to another health condition?
   f. New loss of sense of smell or taste that you cannot attribute to another health condition?

   _____ YES  _____ NO

3. Are you living with or caring for an individual with known or suspected COVID-19?

   _____ YES  _____ NO

4. In the last 14 days, have you been in close contact with anyone with suspected or confirmed COVID-19?

   _____ YES  _____ NO

5. In the last 14 days, have you attended a gathering of more than five people outside your household where physical distancing was not observed and/or people were not wearing face coverings?

   _____ YES  _____ NO

If you are sick or responded yes to any of the questions do not enter the facility. Contact your health care provider for medical guidance.

I read the statement above and attest that the answers are accurate, to the best of my knowledge:

PRINT PARENT NAME          PARENT SIGNATURE          DATE