

COVID19 Symptoms Consent

Student's Name	DOB	Guardian's Name (If applicable)	Symptoms Consent	Signature
			I understand the importance of staying away from lessons if myself or someone I have interacted with has shown COVID19 symptoms in the last fortnight. If symptoms appear, I will make sure to inform PDS so others can be informed. I agree that by coming to lessons that I am safe to be here.	
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