**El Dorado Union High School District**

**COVID-19 | Sent home/Return to School or Work Screening Tool  
Symptom Based**

Individual Name:       Date of Birth:        
ID#:       Site:        
Date:       Phone#:

Interview Conducted: In-Person  Phone Call Other:        
Person Interviewed: Individual  Parent:       Other:

| COVID Positive | | |
| --- | --- | --- |
| 1. Date diagnosed with COVID-19 or Start of symptoms | |  |
| 2. Date first COVID-19 symptoms appeared  *\*If none, go to “asymptomatic positive” below*  Which symptoms did the individual have while ill with COVID-19? | |  |
| Fever/Chills  Congestion or runny nose  Cough  Shortness of breath  Muscle or body aches  Loss of taste or smell | Diarrhea  Nausea/Vomiting  Fatigue  Headache  Sore throat  Other: |
| 3. Have the above symptoms resolved? | | Yes   No |
| 4. Have 10 days *passed* since symptoms first appeared? **Or** negative Covid-19 test.  \*If NO, individual must continue to isolate/quarantine | | Yes  No\* |
| 5. Date of last fever or took a fever-reducing medication  \*If febrile or took medication in last 24 hours, individual must  continue to isolate/quarantine | |  |
| Close Contact Quarantine | |  |
| Date of last exposure | |  |
| Anticipated date of return to school (14 days after known exposure) | |  |
| Asymptomatic Positive | | |
| Date of Collection | |  |
| Example: date of collection 6/11, positive, never had symptoms.  Day 1 of 10 days starts on 6/12, return to school on 6/22. | | |
| Anticipated date of return to school | |  |

Resolution

Continue to use daily self-health screening tool. Advised to contact physician if symptoms develop or are worsening

May return to school on anticipated date of return, as noted above

Medical Provider/Health Department Clearance required prior to return (attach copy when received)   
 Continue to isolate/quarantine. Follow up call recommended on ­

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Credentialed School Nurse Date