**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