COVID-19 Symptom Assessment

Student Name: _____ **Date:** _____ **Time in**: _____ **Time Out:** _____

Clinical Findings: Temp:_____ RR:_____ HR: _____ BP:_____/_____Other:_____

Symptoms:

- ☐ Fever of _____
- ☐ Chills
- ☐ Sore Throat
- ☐ Cough
- ☐ Difficulty breathing or shortness of breath
- ☐ Fatigue
- ☐ Muscle or body aches
- ☐ New loss of taste or smell
- ☐ Stomach Ache
- ☐ Nausea
- ☐ Vomiting/ Diarrhea
- ☐ Headache
- ☐ Congestion or runny nose
- ☐ Other_____

****** THE ABOVE SYMPTOMS REQUIRE YOUR ENTIRE HOUSEHOLD TO STAY HOME**********

Per Arizona Department of Health Services - Your child and all household members must stay home and away from others or under isolation until everyone have met all 3 requirements below.

1. At least 10 days have passed since symptoms first appeared.
2. At least 24 hours have passed since last fever without the use of medication that reduces fever
3. Other symptoms have improved

If your child tests NEGATIVE for COVID-19 they may return to school as long as:
24 hours have passed since last fever without the use of medicine that reduces fever
AND
Other symptoms have improved.
OR
If your child receives a "Ok to Return to school" note from a physician

You must contact the health office prior to your child returning to school: 696-_____

Return to school date: _____

★ **I acknowledge that I understand the information presented regarding my child and their current symptoms.**

_____/_____/_____

Parent Printed Name | Parent/Guardian Signature | Date

If your child develops emergency signs of COVID-19, GET MEDICAL ATTENTION IMMEDIATELY!
*Difficulty getting air * Chest Pain * Change in Alertness * Bluish Lips or Face * Rapid Breathing*