FAMILY HEALTH SCREENING TOOL

Parent/Family Name: _____ Date: _____

Child(ren) Name(s): _____

Daily Screening Guidance

This guidance is intended for parents to use as a guide for at-home screenings on a daily basis. For **daily screenings**, it is not expected that a form be completed and submitted to the school office.

Completion and Submission Requirements for this Form

We ask that this form be completed and submitted to the school office upon arrival when:

- The first day of school
- Your child returns to school following an absence due to exclusion from any illness including COVID-19.
- When anyone in the family is presenting cold, flu-like or COVID symptoms.

Does the child have any ONE of the following? (Single symptom list)

O YES	O NO	FEVER
O YES	O NO	REPEATING SHAKING WITH CHILLS
O YES	O NO	DRY COUGH
O YES	O NO	NEW LOSS OF TASTE OR SMELL
O YES	O NO	SHORTNESS OF BREATH OF DIFFICULTY BREATHING
O YES	O NO	VOMITING
O YES	O NO	DIARRHEA

Does the child have TWO of the following? (Multiple symptom list)

O YES	O NO	FATIGUE
O YES	O NO	MUSCLE ACHES
O YES	O NO	HEADACHE
O YES	O NO	SORE THROAT
O YES	O NO	NAUSEA
O YES	O NO	CONGESTION OR RUNNY NOSE

Has anyone in the household experienced any of the previous symptoms in the last 24 hours?

O YES O NO (If yes, please identify) _____

_____

Has anyone in the household tested positive for COVID-19 in the last two weeks or currently have a COVID test with pending results?

O YES O NO (If yes, what was the result?) _____

In the week before feeling sick, did you:

O YES O NO Have contact with someone diagnosed with COVID-19?

Notes:

- **Exclusion from school will occur if any ONE of the single item symptoms are checked yes OR if TWO of the multiple symptoms are checked yes.**

- **Return to school: Return to school after COVID + test or suspected COVID infection may not occur until 10 days after either the onset of symptoms or the date the positive test was collected AND the below criteria have been met.**

- **GENERAL SYMPTOMS: If your child or anyone in your family has experienced any of the related symptoms listed above, your child will be excluded until they are either (1) symptom free or (2) there is significant improvement in symptoms for NO LESS than 24-hours.**

- **FEVER RULE: If your child HAS A FEVER, they cannot return to school until 72-hours from the last fever (temperature of greater than 100.4) without the use of fever reducing medications (unless FEVER is associated with another diagnosis other than COVID-19 which will require a *doctor's note upon return.***

  If ANYONE living within the household has a pending COVID test as *RECOMMENDED BY A MEDICAL PROFESSIONAL,* is exhibiting symptoms, or has been exposed to COVID-19, your child will be excluded for 14 days from the date of sample for a positive test or the family member's onset of symptoms.

Signature:

By signing this document, I affirm the answers to these statements are true and accurate to the best of my knowledge.

Signature: _____ Date: _____

** This form is subject to change based on current LLCHD/DHHS Guidelines.