COVID-19 Student Triage: PLEASE RETURN THIS FORM TO THE SCHOOL NURSE

Student Name: _____

Date evaluated in Health Center: _____

SECTION 1:

Presenting Symptoms Group A - 1 or more symptoms	Group B - 2 or more symptoms
☐ **Fever** (100.0 or higher) ☐ **Cough** (new uncontrolled cough that causes difficulty breathing, for students with chronic allergic/asthmatic cough, a change in their cough from baseline) ☐ **Shortness of breath** ☐ **Difficulty breathing*** ☐ **New lack of smell or taste**	☐ Sore throat ☐ Runny nose/congestion ☐ Chills ☐ Muscle pain ☐ Nausea or vomiting ☐ Headache ☐ Diarrhea

.

Other:_____

Clinical Findings:

Date/Time Symptoms began: _____

Temp: _____ o F SpO2: _____% RR: _____bpm HR: _____bpm

BP: _____/_____

Notes:_____

_____

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SECTION 2: Close Contact/ Potential Exposure

☐ Had close contact (within 6 feet, of cumulative time, for at least 15 minutes) with a person with confirmed COVID-19.
☐ Had close contact (within 6 feet, of cumulative time, for at least 15 minutes) with a person under quarantine for possible exposure to COVID-19.
☐ Traveled via public transportation (plane or train) within the last 14 days.
☐ No known exposure

Parents notified to pick up their child and refer to their Primary Care Physician at:

_____
Time

Your student presented to the Nurse's Office with symptoms that would require them to stay home and to refer to their medical provider regarding potential testing for COVID-19. Please ensure your student meets the following criteria before returning to school.

Return to School Guidelines

Situation	Returning to School
☐ **Student tests positive for COVID-19**	1. At least three days (72 hours) have passed since resolution of fever without the use of fever-reducing medications AND; 2. The student is free of symptoms AND; 3. At least 10 days have passed since symptoms first appeared
☐ **Student has symptoms that could be COVID-19 and who is not evaluated by a medical professional or tested for COVID-19**	Student is assumed to have COVID-19 and must complete the same three-step set of criteria listed above before returning to campus.
☐ **Student has symptoms that could be COVID-19 and wants to return before completing the stay at home period**	(a) Medical professional complete this form clearing the individual to return based on an alternative diagnosis **OR** (b) Receive two separate confirmation tests at least 48 hours apart that they are free of COVID-19

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Section 3: Clearance to return to School

Student Name: _____

Date of evaluation: _____

Return to school date: _____

Diagnosis: _____

Restrictions:_____

***If the student is an athlete, a Post COVID Clearance will be required after recovery**

Additional Information:_____

Provider Name: _____

Please check the appropriate box

☐ I have evaluated _____ and deemed it necessary for him/her to remain at home for at least 10 days and may return to school after the ten days as long as he/she has been fever free for 72 hours without fever reducing medications AND symptoms have improved.

☐ I have evaluated _____ and diagnosed him/her with an alternative diagnosis other than COVID-19. He/She may return to school on _____.

Provider Signature: _____

Contact Number: _____

Date: _____

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