



COVID-19 STUDENT TRIAGE FORM

SCHOOL HEALTH – COVID-19 TESTING

People with COVID-19 have had a wide range of symptoms reported- ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. Any student with symptoms consistent with COVID-19 should be referred to the school nurse for evaluation on whether testing is needed. **These symptoms should be outside of the student's baseline.**

- | | | | |
|----------------------------|----------------------|-------------------|-----------------|
| Fever | Cough | Fatigue | Headache |
| Sore Throat | Congestion | Runny Nose | Diarrhea |
| Shortness of Breath | Difficulty Breathing | Muscle/Body Aches | Nausea/Vomiting |
| New Loss of Taste or Smell | | | |

Name: _____ Date: _____ Time: _____

SECTION 1: Presenting symptoms:

Group A <i>(one or more symptoms)</i>	Group B <i>(two or more symptoms)</i>
<input type="checkbox"/> Fever ≥ 100.4 <input type="checkbox"/> *New, uncontrolled cough <i>(For asthmatic students, a change in cough from their baseline)</i> <input type="checkbox"/> Difficulty breathing/shortness of breath <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Sore throat with inflammation	<input type="checkbox"/> Runny nose <input type="checkbox"/> Congestion <input type="checkbox"/> Chills <input type="checkbox"/> Loss of taste or smell <input type="checkbox"/> Muscle pain/body aches <input type="checkbox"/> Nausea <input type="checkbox"/> Headache <input type="checkbox"/> Fatigue

- Other Symptoms: _____
**If coughing, does the student have asthma? If so, follow his/her asthma action plan. If the student is having severe difficulty breathing, shortness of breath, difficulty speaking or lips are blue call 911.*

When did symptoms begin? _____

Clinical Findings:

Temp: _____ °F SaO2: _____% RR: _____bpm HR: _____bpm BP: _____/_____

Notes: _____

Nurse Signature: _____ Date: _____

Parents/guardians notified to pick up their child and refer to their medical provider at:

Your child/student presented to the health clinic with symptoms that would require him/her to stay home and to refer to your medical provider regarding potential testing for COVID-19. Please ensure your student meets the criteria before he/she returns to school.

RETURN TO SCHOOL GUIDELINES

SITUATION		RETURNING TO SCHOOL
<input type="checkbox"/>	Student exhibits one (1) or more symptoms from Group A or two (2) or more symptoms from Group B	<p>The individual can return to school if</p> <ul style="list-style-type: none"> <input type="checkbox"/> 10 days have passed since symptoms first appeared. AND <input type="checkbox"/> Fever free for 24 hours, without the use of fever-reducing medication AND <input type="checkbox"/> Improvement in symptoms (e.g., cough, shortness of breath) OR <input type="checkbox"/> Obtain a test at an approved testing location that comes back negative for COVID-19 AND/OR <input type="checkbox"/> Obtain a medical professional's *note clearing student for return based on an alternative diagnosis AND <input type="checkbox"/> Fever-free for 24 hours, without the use of fever-reducing medication
<input type="checkbox"/>	Positive for COVID-19	<p>The individual can return to school if</p> <ul style="list-style-type: none"> <input type="checkbox"/> 10 days have passed since symptoms first appeared. AND <input type="checkbox"/> fever-free for 24 hours, without the use of fever-reducing medication AND <input type="checkbox"/> Improvement in symptoms (e.g., cough, shortness of breath)

Return to school date: _____

****Please make sure notes from the medical provider clearing students for return are given to the school nurse. Thank you.***