**Health Screening Assessment COVID-19 Questionnaire for the Early Intervention Program**

**Purpose:** As mandated by the Suffolk County Department of Health, this form must be completed for every household/childcare setting and teacher, therapist, or evaluator prior to each session or evaluation to screen for possible exposure to the COVID-19 virus. Answers will remain **confidential** in accordance with State and federal law and maintained by the provider. In the interest of Suffolk County’s Public Health Mandate, the form will be available for inspection upon the request of the Suffolk County Department of Health.

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| **Section 1** | **Teacher/Therapist/Evaluator/On-going Service Coordinator Information (Provider)** | | |
| Date: | First Name: | Last Name: | |
| Independent Provider | Agency Name: | | |
| Provider’s Phone Number: | | Provider’s Email: | |
| Service/Eval Type: | | | Location of Service Session/Evaluation:  Home  Community  Office/Facility □ Daycare |
| Address of Session/Evaluation: | | | |

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| --- | --- | --- | --- | --- |
| **Section 2** | **Parent/Guardian Information** | | | |
| Date: | First Name: | | Last Name: | |
| Parent/Guardian of: | | | | Child’s Date of Birth: |
| Parent/Guardian Phone number: | | Parent/Guardian Email: | | |

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| **Section 3** | **Questions** | **Provider Response** | **Parent/Guardian Response** |
| **Has anyone in the household or childcare setting**: | | | |
| 1. Tested positive for COVID-19 in the past 14 days? | | Yes □ -or- No □ | Yes □ -or- No □ |
| 1. Experienced symptoms of COVID-19 in the past 14 days? (symptoms include, but are not limited to: cough, shortness of breath or difficulty breathing, fever, chills, muscle pain, sore throat, new loss of taste and/or smell or temperature of 100°or more)   **Important: For a temperature to be considered as normal, it must register lower than 100° F without fever reducing medications.** | | Yes □ -or- No □ | Yes □ -or- No □ |
| 1. During the past 14 days, been in close contact with anyone who has tested positive for COVID-19 or who has/had symptoms of COVID-19? | | Yes □ -or- No □ | Yes □ -or- No □ |
| 1. In the past 14 days, spent longer than 24 hours in a state that is (or was before you left the state) on the NY Governor’s list of states requiring quarantine? | | Yes □ -or- No □ | Yes □ -or- No □ |

**Provider Signature:** I hereby affirm that to the best of my knowledge all answers above are true.

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Provider Name Signature Date

**Parent/Guardian/Caretaker Signature:** I hereby affirm that to the best of my knowledge all answers above are true.

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Parent/Guardian/Caretaker Name Signature Date

*Immediately upon completion, please maintain this form as part of the child’s Early Intervention Record*. 09/18/2020