**Suffolk County Department of Health COVID-19 Health Screening Assessment**

As mandated by the Suffolk County Department of Health, this form must be completed for every household and provider **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.

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| --- | --- |
| **Section 1** | **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:[ ] In the home [ ]  Outdoors |
| **Address of Session/Evaluation:** |

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

|  |  |
| --- | --- |
| Section 3 | Record Temperature (must be lower than 100 F without fever reducing medications) |
| Provider | Household Members | Household Members | Household Members | Household Members | Household Members | Household Members |
|  |  |  |  |  |  |  |

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| --- | --- | --- | --- |
| **Section 4** | **Questions** | **Provider Response** | **Parent/Guardian Response for All** |
| Have you or anyone in your household tested positive for COVID-19 in the past 14 days? | Yes □ -or- No □ | Yes □ -or- No □ |
| Has anyone 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, headache, muscle or body aches, sore throat, congestion or runny nose, nausea or vomiting, diarrhea, fatigue, or new loss of taste and/or smell) | Yes □ -or- No □ | Yes □ -or- No □ |
| Have you been in close contact in the past 14 days with anyone who has tested positive for COVID-19 or who has or had symptoms of COVID-19? | Yes □ -or- No □ | Yes □ -or- No □ |
| Note: Any questions that are answered as a “Yes” must be followed with a call to the provider agency who may reach out to Nassau County Department of Health for guidance. |

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

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 Parent/Guardian Name Signature Date

*Immediately upon completion, please maintain this form as part of the child’s School Record*. 06/24/2020