

# COVID-19 Health Screening Checklist for CHILDREN

Person conducting screening should maintain 6 feet of distance from child while asking questions. Questions should be posed to parents of small children; children old enough to understand and answer for themselves may be asked directly. Tool intended to assist programs to screen for COVID-19, but should not replace other communicable disease screening tools or protocols for school programs.

## Part 1

	YES	NO
Is your child not up to date on recommended COVID-19 vaccinations AND been in close contact with anyone who tested positive for COVID-19 or was diagnosed with COVID-19 in last 10 days?*	<input type="checkbox"/>	<input type="checkbox"/>
Has your child been diagnosed with COVID-19 by a health care provider in the last 10 days?*	<input type="checkbox"/>	<input type="checkbox"/>
Has your child developed any of the following symptoms within the past 24 hours?		
➤ Cough	<input type="checkbox"/>	<input type="checkbox"/>
➤ Shortness of breath/trouble breathing	<input type="checkbox"/>	<input type="checkbox"/>
➤ New loss or sense of taste or smell	<input type="checkbox"/>	<input type="checkbox"/>
➤ Fever or took medication in the past 24 hours to lower temperature (e.g., Tylenol)?	<input type="checkbox"/>	<input type="checkbox"/>
➤ New confusion	<input type="checkbox"/>	<input type="checkbox"/>
➤ Persistent pain or pressure in the chest	<input type="checkbox"/>	<input type="checkbox"/>
➤ Pale, gray, or blue-colored skin, lips, or nail beds, depending on skin tone	<input type="checkbox"/>	<input type="checkbox"/>
➤ Inability to wake or stay awake	<input type="checkbox"/>	<input type="checkbox"/>

\*Child may be able to return after 5 days if able to wear a well-fitting mask.



**If YES to any question in Part 1, the child should be sent home.  
If NO to all questions in Part 1, proceed to Part 2.**

## Part 2

**Has your child developed any of the following symptoms within the last 24 hours?**

	YES	NO		YES	NO
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>
Unusual fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Muscle or body aches	<input type="checkbox"/>	<input type="checkbox"/>
Nausea ( <i>sick to stomach</i> ) or vomiting▲	<input type="checkbox"/>	<input type="checkbox"/>	Fever ( $\geq 100.4^{\circ}\text{F}$ ) or chills ( <i>would indicate fever</i> ) ▲	<input type="checkbox"/>	<input type="checkbox"/>
Runny nose or nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea▲	<input type="checkbox"/>	<input type="checkbox"/>



**If YES to 2 or MORE questions in Part 2, child should be sent home.**

**If YES to 0 or 1 question(s) in Part 2, child may remain at facility.**

### Child to be sent home

- Record child's name, symptoms, and the date symptoms started in your illness log/line list.
- Child should be **immediately sent home** to isolate and should be tested for COVID-19.

### Child may remain at facility

Child should wash (or sanitize) hands before having contact with other children or staff.

▲Vomiting, diarrhea, and fever—alone or together—should exclude a child from school.