



Symptom Presentation Documentation

Student _____ Grade _____ Teacher _____

Group A: 1 or More High Risk Symptoms	Group B: 2 or More Low Risk Symptoms
<input type="checkbox"/> Fever (100.4 or higher) <input type="checkbox"/> Cough (new uncontrolled cough that causes difficulty breathing, for students with chronic allergic/asthmatic cough, a change in their cough from baseline) <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty breathing* <input type="checkbox"/> New loss of taste or smell <i>*With 1 or more high-risk symptom(s), please see a physician.</i>	<input type="checkbox"/> Sore throat <input type="checkbox"/> Runny nose/congestion <input type="checkbox"/> Muscle pain/body aches/myalgia <input type="checkbox"/> Headache <input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting/nausea <input type="checkbox"/> Fatigue/tiredness <i>* With 1 low-risk symptom: Return to school if 36 hours fever-free and symptoms have improved</i> <i>* With 2 low-risk symptoms: Please see your provider for testing, evaluation, and a possible alternate diagnosis.</i>

**If coughing, does the student have asthma? If so, please follow his/her asthma action plan. If the student is having severe difficulty breathing, shortness of breath, difficulty speaking, or lips are blue, call 9-1-1.*

☐ Other: _____

Clinical Findings: Date/Time symptoms began: _____

Temp: _____ SpO2: _____ % RR: _____ HR: _____ bpm

Notes:

Staff/Clinical Signature _____

Date: _____