**Needville ISD COVID-19 Triage:**

**PLEASE RETURN THIS FORM TO THE REGISTERED NURSE FOR YOUR CAMPUS**

 **□ Needville Elementary** **□ Needville Middle School**

PHONE: 979.793.4308 PHONE: 979.793.3027

 FAX: 979.793.2299 FAX: 979.793.7665

**□ Needville Junior High □ Needville High School** PHONE: 979.793.4250 PHONE: 979.793.5158

FAX: 979.793.4575 FAX: 979.793.5590

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Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_

**SECTION 1: Presenting symptoms:**

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| Patient presents with the following symptoms: |
| * Fever (100.4 or higher)
* \*Cough **(new uncontrolled cough that causes difficulty breathing, for students with chronic allergic/asthmatic cough, a change in their cough from baseline)**
* Shortness of breath
* Difficulty Breathing
 | * Sore throat
* Runny nose/congestion
* Chills
* New lack of smell or taste
* Muscle pain
* Nausea or vomiting
* Headache
* Diarrhea
 |

* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*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: \_\_\_\_\_ ℉ SaO2: \_\_\_\_% RR: \_\_\_\_bpm HR: \_\_\_\_\_\_bpm BP:\_\_\_\_/\_\_\_\_\_

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_

**Section 2: Close Contact/ Potential Exposure**

* + Had close contact (within 6 feet of an infected person for at least 15 minutes) with a person with confirmed COVID-19
	+ Had close contact (within 6 feet of an infected person for at least 15 minutes) with person under quarantine for possible exposure to COVID-19
	+ Traveled to or in an area where the state health department is reporting large numbers of COVID-19 cases, and or a state that the TX Dept. of Health currently recommend that you quarantine for 14 days

Parents notified to pick up their child and refer to their Primary Medical Provider at: \_\_\_\_\_\_\_\_\_\_\_

 TIME

**An individual presented to the health clinic with symptoms that would require him/her to stay home and to refer to their medical provider regarding potential testing for COVID-19. Please ensure the following criteria are met prior to returning to school.**

**Return to School Guidelines**

|  |  |
| --- | --- |
| **Situation** | **Returning to School** |
|  | If a symptom was present, but no positive test, or no evidence of exposure. Students or staff with potential exposure must be checked by school nurse prior to return. | The student will be excused from school until symptom-free for 24 hours, without fever reducing medications. Request a note from your medical provider indicating the student may return to school or have them complete this form.  |
|  | Positive for COVID-19 or possible exposure/close contact  | The individual may return to school when the following are met: * 10 days have passed since symptoms first appeared -OR- 14 days have passed since possible exposure.
* fever-free for 24 hours, without the use of fever-reducing medication
* Symptoms have significantly improved
 |

Return to school date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_