Shamrock Montessori

Back-to-school Staff/ Customers Condition History Form

Information

Name of Staff/Student: First: Last:	Age:	Phone: Email:
Address:		

Past symptoms/medical history

In the past of 14 days, anyone of your family experienced the following illness?
If yes, Who: _____
Date for the symptoms: _____

Fever > 100.4F (38C)	Yes ☐ No ☐	Cough (new onset or worsening of chronic cough	Yes ☐ No ☐
Subjective fever (felt feverish)	Yes ☐ No ☐	Shortness of breath (dyspnea)	Yes ☐ No ☐
Chills	Yes ☐ No ☐	Difficulty breathing	Yes ☐ No ☐
Muscle aches (myalgia)	Yes ☐ No ☐	Wheezing	Yes ☐ No ☐
Runny nose (Rhinorrhea)	Yes ☐ No ☐	Chest pain	Yes ☐ No ☐
Sore throat	Yes ☐ No ☐	Nausea or vomiting	Yes ☐ No ☐
New olfactory and taste disorder(s)	Yes ☐ No ☐	Diarrhea (≥ 3 loose stools/ 24 hr period	Yes ☐ No ☐
Headache	Yes ☐ No ☐	Abdominal pain	Yes ☐ No ☐
Fatigue	Yes ☐ No ☐	Other, specify: _____ _____	

Did the patient's symptoms resolve?
Date of symptom resolution (MM/DD/YYYY): __/__/_____

Note: Follow the Sickness Policy in the school SOP if any of the answers is "yes".

Exposure Information

In the past 14 days, did anyone of your family have any of the following exposures (check all that apply):

- ☐ Domestic travel (outside state of normal residence). Specify state(s): _____
- ☐ International travel. Specify country(s): _____
- ☐ Cruise ship or vessel travel as passenger or crew member. Specify name of ship: ____
- ☐ Airport/airplane
- ☐ Community event/mass gathering.
- ☐ Other exposures, specify: _____
- ☐ Contact a known COVID-19 case (confirmed)

  If the patient had contact with a known COVID-19 case:

  What type of contact?
  - ☐ Household contact
  - ☐ Community-associated contact
  - ☐ Healthcare-associated contact (patient, visitor, or healthcare worker)

Note: Follow the Travel Policy in the school SOP if any of the boxes above is checked.