

Date: _____ Location: MID LAN TC
 Child: _____ Present Guardian: _____

- Question** **Response**
- In the last 14 days has anyone in your household been **diagnosed positive** for COVID-19? No Yes
 - In the last 14 days has anyone in your household been in **close prolonged unprotected contact** with anyone who has **tested positive** for COVID-19? No Yes

If YES answer given to Question 1 or 2.....

- CHILD or HOUSEHOLD MEMBER TEST POSITIVE:** 14 days out from date of onset of symptoms and household be 3 consecutive days’ symptom free without the use of fever-reducing or other symptom-altering medicines (ie cough suppressants).
- CHILD or HOUSEHOLD MEMBER EXPOSED TO AN INDIVIDUAL WHO TESTED POSITIVE:** From the date of contact with the tested individual at least 10 days out and household be 3 consecutive days’ symptom -free without the use of fever-reducing or other symptom-altering medicines (ie cough suppressants).

- In the past 7 days, has anyone in your household displayed any of the following symptoms not related to another health concern?

Symptom	Child	Present Guardian	Other household member...	IF YES answer given in Question 3.....
Fever > 100.4	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<ul style="list-style-type: none"> CHILD IS SYMPTOMATIC: 10 days out from date of onset of symptoms and household be 3 consecutive days’ symptom free without the use of fever-reducing or other symptom-altering medicines (ie cough suppressants). CHILD EXPOSED TO A SYMPTOMATIC HOUSEHOLD MEMBER: 14 days out from date from the date of onset of symptoms of the individual.
New cough	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Sore throat	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Acute Loss of Sense of Smell and/or Taste	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Shortness of breath	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

- In the past 14 days has anyone in your household traveled outside of the Michigan for reasons other than “commuting” to one’s home and/or work? No Yes

If YES answer given to Question 4.....

14 days out from the date of return of travel.

	CHILD	PRESENT GUARDIAN
TEMP > 100.4 Degrees	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES

* CLOSE PROLONGED CONTACT = Less than 6 feet for more than 10 minutes

* UNPROTECTED = Not wearing applicable PPE or adhering to social distancing guidelines

If you answered “YES” to any of the above questions,
 Call the office, your in-clinic session will be cancelled
 and a Team Member will contact you with further information and guidance.