Nassau County Department of Health COVID-19 Health Screening Assessment

As mandated by the Nassau County Department of Health, this form must be completed for every household and provider for all in-person services **prior to each session or evaluation** to screen for possible exposure to the COVID-19 Virus. Answers should be documented from the parent/guardian/caretaker (preschool/daycare staff). Answers will remain **confidential** in accordance with State and federal law and maintained by the provider.

Section 1	**Provider**
First Name:	Last Name:
☐Independent Provider	☐ Agency Name:
Provider's Phone Number:	Provider's Email:
Service/Eval Type:	Location of Service Session/Evaluation: ☐ home ☐ community ☐ office/facility☐ preschool/daycare
Address of Session/Evaluation:	

Section 2	**Parent/Guardian/Caretaker Information**
First Name:	Last Name:
Child's Name:	Child's Date of Birth:
Parent/Caretaker Phone number:	

Date of Service	Have you or anyone in your household tested positive for COVID-19 in the past 10 days?	Has anyone experienced symptoms of COVID-19 in the past 10 days? (symptoms include, but are not limited to: cough, shortness of breath or difficulty breathing, fever, chills, headache, muscle or body aches, sore throat, congestion or runny nose, nausea or vomiting, diarrhea, fatigue, or new loss of taste and/or smell or temperature of 100° or more) **Important: For a temperature to be considered as normal, it must register lower than 100° F without fever reducing medications.**	Has anyone been in close contact in the past 10 days with anyone who has tested positive for COVID-19 or who has or had symptoms of COVID-19?	**Parent/Caretaker & Provider Signature** *I hereby affirm that to the best of my knowledge; all answers are true. Parent/Caretaker should sign the top line. Provider should sign the bottom line.
	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	*______________________ *______________________
	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	*______________________ *______________________
	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	*______________________ *______________________
	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	*______________________ *______________________
	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	*______________________ *______________________

FOR ANY "YES" RESPONSE, AGENCY PROVIDERS SPEAK TO YOUR AGENCY; FOR INDEPENDENT CONTRACTORS, CONTACT THE COVID CALL CENTER AT 516 227-9570 FOR INSTRUCTIONS.

Indicate Agency or Covid Call Center Response:

Upon completion, please maintain this form as part of the child's case file.