

Westchester County Department of Health COVID-19 Health Screening Assessment

As mandated by the Westchester County Department of Health, this form must be completed for every household and provider **prior to each session or evaluation** to screen for possible exposure to the COVID-19 Virus. Answers will remain **confidential** in accordance with State and Federal Law and maintained by the provider.

Section 1		Provider	
Date:	First Name:	Last Name:	
<input type="checkbox"/> Independent Provider	<input type="checkbox"/> Agency Name:		
Provider’s Phone Number:		Provider’s Email:	
Service/Eval Type:		Location of Service Session/Evaluation:	
		<input type="checkbox"/> In the home <input type="checkbox"/> Outdoors	
Address of Session/Evaluation:			

Section 2		Parent/Guardian Information	
Date:	First Name:	Last Name:	
Parent/Guardian of (child’s name):			Child’s Date of Birth:
Parent/Guardian Phone number:			

Section 3	Record Temperature (must be lower than 100 F without fever reducing medications)					
Provider	Household Members	Household Members	Household Members	Household Members	Household Members	Household Members

Section 4	Questions	Provider Response	Parent/Guardian Response for All
	Have you or anyone in your household tested positive for COVID-19 in the past 14 days?	Yes <input type="checkbox"/> -or- No <input type="checkbox"/>	Yes <input type="checkbox"/> -or- No <input type="checkbox"/>
	Has anyone experienced symptoms of COVID-19 in the past 14 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)	Yes <input type="checkbox"/> -or- No <input type="checkbox"/>	Yes <input type="checkbox"/> -or- No <input type="checkbox"/>
	Have you been in close contact in the past 14 days with anyone who has tested positive for COVID-19 or who has or had symptoms of COVID-19?	Yes <input type="checkbox"/> -or- No <input type="checkbox"/>	Yes <input type="checkbox"/> -or- No <input type="checkbox"/>
Note: Any questions that are answered as a “Yes” must be followed with a call to the provider agency who may reach out to Westchester County Department of Health for guidance.			

Provider Signature: I hereby affirm that to the best of my knowledge, all answers above are true.

Provider NameSignatureDate

Parent/Guardian Signature: I hereby affirm that to the best of my knowledge, all answers above are true.

Parent/Guardian NameSignatureDate