



## Investigating COVID-19 Cases

(To be completed by School Nurse or trained school personnel)

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

DOB: \_\_\_\_\_ ☐ Staff Member ☐ Student School Site: \_\_\_\_\_

Phone # (s): \_\_\_\_\_

Address: \_\_\_\_\_

Interview Conducted: ☐ In-Person ☐ Phone Call ☐ Other: \_\_\_\_\_

Person Interviewed: ☐ Staff ☐ Student & Parent/Guardian: \_\_\_\_\_





### INTAKE HISTORY

1. Date that staff/student referred to Health Office	Date: _____	
2. Why was the student/staff referred for Covid- 19 follow-up assessment? (May check more than one box)	<input type="checkbox"/> Possible Covid-19 Symptom(s) <input type="checkbox"/> Positive Covid- 19 lab test <input type="checkbox"/> Possible Exposure to a positive Covid- 19 case <input type="checkbox"/> Other: _____	
3. Has the staff/student had any of the following symptoms of Covid-19?	<input type="checkbox"/> Chills <input type="checkbox"/> Diarrhea <input type="checkbox"/> Congestion or runny nose <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Cough <input type="checkbox"/> Fatigue <input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Headache <input type="checkbox"/> Muscle or body aches <input type="checkbox"/> Sore throat <input type="checkbox"/> Loss of taste and/or smell <input type="checkbox"/> Temperature 100.4 or greater <input type="checkbox"/> Other: _____
4. Has the staff/student had a Covid- 19 test? If yes, then <ul style="list-style-type: none"> <li>What date was the Covid-19 test performed?</li> <li>Results of test</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ <input type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE	
5. Has the staff/student had close contact with an individual who is a confirmed Covid- 19 case? <i>Definition of a close contact: An individual who was within 6 feet of an infected person for at least 15 minutes starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to positive specimen collection) until the time the patient is isolated</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>➤ Per the information gathered from the Intake Questions, CIRCLE the appropriate Scenario and then</p> <p>➤ Proceed to the Scenario follow up categories on following pages</p>	<input type="checkbox"/> 1. Staff/student has Covid- 19 symptoms only <input type="checkbox"/> 2. Staff/student is a close Covid- 19 contact <input type="checkbox"/> 3. Staff/student has a positive Covid- 19 test <input type="checkbox"/> 4. Staff/student had negative test after symptoms	

## 1. Covid- 19 Symptoms Only

1. What date did the COVID-19 symptoms first appear?	Date: _____
2. Does staff/student have a chronic illness that causes them to have their current symptoms? <i>(The interviewer cannot make the decision to attribute the symptoms to a chronic illness)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____

### Follow- Up Steps with Student/Staff with Covid- 10 Symptoms Only

- ☐ Stay home and isolate per Nevada County Public Health Guidelines (Give NCPHD Handout- HOME ISOLATION INSTRUCTIONS FOR NOVEL CORONAVIRUS-2019 (COVID-19))
- ☐ Recommend physician visit and/ or Covid- 19 test
- ☐ Depending on the follow up actions of staff/student, the return to work criteria is based on one of the following:
  -  **A.** If the staff/student answered YES to one or more of the Daily Symptom Check questions and they followed up with a **Covid- 19 test that had a negative result, then refer to Scenario 4.**
  -  **B.** If the staff/student answered YES to one or more of the Daily Symptom Check questions and they followed up with a **Covid- 19 test that had a positive result, then refer to Scenario 3.**
  -  **C.** If the staff/student answered YES to one or more of the Daily Symptom Check questions and **they have not had a Covid- 19 test**, then they should consult their healthcare provider who will decide if they are a candidate for Covid- 19 testing.
    - ☐ If the physician recommends testing, then depending on the result of the test, see A or B above.
    - ☐ If testing is not recommended by their healthcare provider, then staff/student may return to work/school when the following conditions are met:
      - ☐ Symptoms are resolving (not necessarily completely resolved)
      - ☐ Fever free for 24 hours without the use of fever reducing medications
      - ☐ 24 hours without an incidence of diarrhea
      - ☐ Submission to school of physician note stating the Covid-19 test not needed
  -  **D.** If the staff/student answered YES to one or more of the Daily Symptom Check questions and **they have not had a Covid test and have chosen not to contact their healthcare provider**, then they may return to work/school when the following conditions are met:
    - ☐ It has been 10 days since the onset of symptoms
    - ☐ Symptoms are resolving (not necessarily resolved)
    - ☐ Fever free for 24 hours without the use of fever reducing medications
    - ☐ 24 hours without an incidence of diarrhea

### INITIAL STAFF/ STUDENT FOLLOW UP PLANS:

2. Close COVID- 19 Contact	
1. Did the infected person have a positive Covid- 19 test?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. What was the date that you last had close contact with the infected person?	Date: _____
3. What was the date that the infected person first developed symptoms?	Date: _____
4. Have you had any Covid- 19 symptoms? (See above) If yes, then the date these symptoms first appeared.	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____
5. Have you been contacted by Nevada County Public Health?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Follow- Up Steps in staff/student with a Close Covid- 19 Contact</b>	
<input type="checkbox"/> <b>If staff/student meets criteria for a close contact and <u>does not develop</u> symptoms of Covid- 19 then:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Send home to quarantine for 10 days from last exposure to confirmed Covid positive case</li> <li><input type="checkbox"/> All contacts released from quarantine before Day 14 must: <ul style="list-style-type: none"> <li>• Self-monitor for COVID-19 symptoms through Day 14 and if symptoms occur, immediately self-isolate and contact their local public health department or healthcare provider and seek testing.</li> <li>• Adhere strictly to all recommended non-pharmaceutical interventions, including consistent use of face coverings and maintaining a distance of at least 6 feet from others, through Day 14.</li> </ul> </li> <li><input type="checkbox"/> Give NCPHD Handout: Home Quarantine Guidance for Close Contacts to Coronavirus Disease</li> <li><input type="checkbox"/> Recommend Covid- 19 Test (but will not shorten 10-day quarantine. Please wait 7 day before obtaining a test after exposure.)</li> </ul>	
<input type="checkbox"/> <b>If staff/student meets criteria for a close contact and <u>develops symptoms</u> of Covid-19 then:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Home Isolation: Give NCPHD Handout Home Isolation Instructions for People with Coronavirus-2019</li> <li><input type="checkbox"/> Recommend physician visit and/or Covid- 19 Test</li> <li><input type="checkbox"/> Anticipated date of return to work/school is when the following criteria are met: <ul style="list-style-type: none"> <li>○ 10 days after symptoms first appeared AND</li> <li>○ Your fever is gone for at least 24 hours without the use of fever-reducing medications AND</li> <li>○ Your other symptoms (e.g. cough, shortness of breath, aches, sore throat, etc.) are improving</li> </ul> </li> </ul>	
<input type="checkbox"/> <b>Report case to school administration for consideration of school community notification of a known contact</b>	
<b>INITIAL STAFF/ STUDENT FOLLOW UP PLANS:</b>	

### 3. COVID- 19 Positive Test

1. What date was the positive Covid-19 test performed?	Date: _____
2. Have you had any Covid- 19 symptoms? (See above) If yes, then the date these symptoms first appeared?	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____
3. Have the symptoms resolved?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have 10 days <i>passed</i> since symptoms first appeared?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Date of last fever or last date that fever-reducing medication was used? ( <i>If febrile or took medication in last 24 hours, then individual must continue to isolate/quarantine</i> )	Date of last fever: _____ Date of Use of last fever reducing medication: _____
6. Have you been contacted by Nevada County Public Health?	<input type="checkbox"/> Yes <input type="checkbox"/> No

#### Follow- Up Steps in staff/ student with a Covid- 19 Positive Test

- ☐ Stay home on Isolation
- ☐ Give NCPHD Handout: Home Isolation Instructions for People with Coronavirus-2019
- ☐ Nevada County Public Health Department will be notified by your school nurse or trained school personnel
- ☐ Identify contacts: Quarantine & Exclude exposed contacts per Covid positive contact algorithm, (likely the entire cohort), for 10 days after the last date that the case was present at school while infectious

**What is a close contact?** *An individual who was within 6 feet of an infected person for at least 15 minutes starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to positive specimen collection) until the time the patient is isolated.*

**\*It may be difficult to determine whether individuals have met this criterion and an entire cohort, classroom, or other group may need to be considered exposed, particularly if people have spent time together indoors.**

- ☐ Disinfection and cleaning of classroom and primary spaces where case spent significant time
- ☐ Report case to administration for consideration of school community notification of a known case
- ☐ May return to work/ school when following criteria met:
  - ☐ If symptoms occurred:
    - ☐ 10 days after symptoms first appeared AND
    - ☐ Your fever is gone for 24 hours without the use of fever-reducing medications AND your other symptoms (e.g. cough, shortness of breath) have improved
  - ☐ If no symptoms occurred:
    - ☐ 10 days after the Covid- 19 test was performed. Example: Date of collection 6/11, positive, never had symptoms. Day 1 of 10 days starts on 6/12, return to school on 6/22

#### INITIAL STAFF/ STUDENT FOLLOW UP PLANS:

4. Negative test after Symptoms	
1. What date did your symptoms appear?	Date: _____
2. What date was the negative Covid – 19 test administered?	Date: _____
<b>Follow- Up Steps in staff/ student with a Covid- 19 Negative Test following Symptoms</b>	
<input type="checkbox"/> May return to work/school when following criteria met: <ul style="list-style-type: none"> <li><input type="radio"/> Symptoms are resolving (not necessarily completely resolved)</li> <li><input type="radio"/> Fever free for 24 hours without the use of fever reducing medications</li> <li><input type="radio"/> 24 hours without an incidence of diarrhea</li> <li><input type="radio"/> Submission to school of negative Covid- 19 test</li> </ul>	
<b>INITIAL STAFF/ STUDENT FOLLOW UP PLANS:</b>	
<b>STAFF/STUDENT EDUCATION (Check all that apply)</b>	
<input type="checkbox"/> Continue to use daily Covid- 19 self-screening tool <input type="checkbox"/> Advised to contact physician if symptoms worsen <input type="checkbox"/> Advised to call 911 or go to an emergency room, if having difficulty breathing, feeling pain or pressure in chest, bluish lips/face, or are experiencing a new onset of confusion or difficulty waking up <input type="checkbox"/> Let your doctor know if you are 65 years or older and/or have health problems such as a chronic disease or a weak immune system as you may be at higher risk of more serious illness.	
<b>RESOLUTION (Check all that apply)</b>	
<input type="checkbox"/> No follow up necessary- staff/student may return to work/school immediately <input type="checkbox"/> After completing the required criteria as noted, staff/student returned to work/ school on: _____	
<b>FOLLOW UP NOTES (Date and sign each note)</b>	
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*Signature of School Personnel Completing Form*


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*Print Name of School Personnel Completing Form*


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*Signature of Credentialed School Nurse*


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*Print Name of Credentialed School Nurse*


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*Date of Case Resolution*

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