

## **Home-based Screening Acknowledgment**

**Sponsors and Caregivers:** Please complete this short check of your student each morning before they leave for school.

**Staff:** Please complete this short check of yourself each morning before you leave for work.

### **Section 1: Symptoms**

If the individual has any of the following symptoms, they might have an illness they can spread to others (for those with chronic conditions, check a symptom only if it has changed from usual or baseline health):

- Fever or feeling feverish (such as chills, sweating)
- Cough
- Mild or moderate difficulty breathing (breathing slightly faster than normal, feeling like you can't inhale or exhale, or wheezing, especially during exhaling or breathing out)
- Sore throat
- Muscle aches or body aches
- Unusual fatigue
- Headache
- New loss of taste or smell
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

### **Section 2: Exposure**

A. Has the individual had close contact with someone with COVID-19?

- Yes
- No

B. Has the individual traveled or arrived from an area where the local, territorial, or state health department is reporting large numbers of COVID-19 cases or are in HPCON C or D?

- Yes
- No

→ **If YES response to any part of Section 1 and NO to both parts of Section 2:**

- The individual should stay home until his or her symptoms have improved, at least 24 hours after they no longer have a fever or signs of a fever (chills, feeling very warm, flushed appearance, or sweating) without the use of fever-reducing medicine (e.g., acetaminophen or ibuprofen).

→ **If YES response to any part of Section 1 and YES to any part of Section 2:**

- Consult with healthcare provider.
- Consult with local public health officials for potential testing and evaluation as a possible close contact.
- Follow applicable public health or local installation quarantine, isolation, and Restriction of Movement (ROM) requirements.

→ **If NO response to Section 1 and YES to any part of Section 2:**

- Consult with local public health officials for potential testing and evaluation as a possible close contact.
- Follow applicable public health or local installation quarantine, isolation, and Restriction of Movement (ROM) requirements.

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I have reviewed the DoDEA Home-based Screening Protocol and agree to conduct the prescreening daily prior to entering a DoDEA facility.

Student or Staff Name: \_\_\_\_\_

School Name or Office Location: \_\_\_\_\_

Student Sponsor or Staff Signature: \_\_\_\_\_

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