



### COVID History form (Pediatric)

#### A. Student's Information:

- 1 Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_
2. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_
3. Birth Gender:  Male  Female

#### B. Student's Current Symptoms:

1. CURRENTLY has fever/chills  Yes  No
2. CURRENTLY have shortness of breath  Yes  No (IF YES PLEASE CALL 911 OR GO TO ER)
3. CURRENTLY has cough  Yes  No
4. CURRENTLY has chest pain  Yes  No (IF YES PLEASE CALL 911 or GO TO ER)
5. New onset loss of taste or smell  Yes  No
6. Body aches  Yes  No
7. Nasal congestion, sore throat, runny nose  Yes  No
8. Other current symptoms : \_\_\_\_\_

#### C. Student's Active Medical Conditions:

1. Asthma/COPD  Yes  No
2. Diabetes  Yes  No
3. Cancer  Yes  No
4. Autoimmune disease  Yes  No
5. Heart Disease  Yes  No
6. Other Chronic Medical Conditions: \_\_\_\_\_

C. Medications Student takes daily:

Student is currently **not** on any medications

Student's list of medications are : \_\_\_\_\_

\_\_\_\_\_

G. Medication student is allergic to

Student has no known medication allergies

Student is allergic to these medications: \_\_\_\_\_

C. Student's Social History:

Student lives with :  Parent(s)  Grandparent(s)  Other: \_\_\_\_\_

Grade level :  Elementary  Middle  High School

***By placing my signature below, I hereby certify that the information I provided above about the student is true and correct.***

Parent's Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_