|  |  |
| --- | --- |
| **Child Information** | **Parent /Guardian Information** |
| Child’s Name: | Name: Phone: |
| Child’s DOB: | Address  |
| **Provider** |
| Name: | Service Type: SI/ABA | Location of Service Session: |

|  |  |
| --- | --- |
| **DATE:** | **Is body temperature lower than 100 F without fever reducing medications?** |
| Provider | Child: | Parent: | Caregiver: | Caregiver: | Caregiver: |
| □ Yes□ No | □ Yes□ No | □ Yes□ No | □ Yes□ No | □ Yes□ No | □ Yes□ No |
| **Questions** | **Provider Response** | **Parent/Guardian response**  |
| Have you or anyone in your household tested positive for COVID-19 in the past 14 days? | □ Yes□ No | □ Yes□ No |
| Has anyone experiences symptoms of COVID-19 in the past 14 days?(symptoms include, but 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□ No | □ Yes□ No |
| 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□ No | □ Yes□ No |
| Note: Any questions that are answered as “Yes” must be followed with a call to NK Progress, Inc. who may reach out to the NY Department of Health for guidance. |
| **Print Name** | **Signature** | **Date** |
| **Provider** |  |  |
| **Parent/Guardian** |  |  |

|  |  |
| --- | --- |
| **DATE:** | **Is body temperature lower than 100 F without fever reducing medications?** |
| Provider | Child: | Parent: | Caregiver: | Caregiver: | Caregiver: |
| □ Yes□ No | □ Yes□ No | □ Yes□ No | □ Yes□ No | □ Yes□ No | □ Yes□ No |
| **Questions** | **Provider Response** | **Parent/Guardian response**  |
| Have you or anyone in your household tested positive for COVID-19 in the past 14 days? | □ Yes□ No | □ Yes□ No |
| Has anyone experiences symptoms of COVID-19 in the past 14 days?(symptoms include, but 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□ No | □ Yes□ No |
| 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□ No | □ Yes□ No |
| Note: Any questions that are answered as “Yes” must be followed with a call to NK Progress, Inc. who may reach out to the NY Department of Health for guidance. |
| **Print Name** | **Signature** | **Date** |
| **Provider** |  |  |
| **Parent/Guardian** |  |  |