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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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** | | | |  | | |  |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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** | | | |  | | |  |