COVID-19 (Coronavirus) Child Screening Questionnaire

With the increased spread of COVID-19, UC Berkeley’s Early Childhood Education Program is taking every precaution to protect the health and safety of its children, staff, and the community at large. As part of our COVID-19 Response Plan and upon the advice of the Department of Developmental Services (DDS), all individuals entering this facility are to complete this COVID-19 screening questionnaire.

This form is to be completed by the parent/guardian of each child entering our care.

Child’s Name (please print): _____________________________________________

1. Has this child, or anyone they have had contact with, recently traveled to a domestic or foreign area severely affected by COVID-19 virus? ☐ Yes ☐ No

2. Within the last 14 days and to the best of your knowledge has this child, or anyone they have had contact with, been infected with COVID-19 virus? ☐ Yes ☐ No

3. Within the last 24 hours has this child experienced any of the following? (Please check all that apply):

   - New or worsening cough, respiratory illness, shortness of breath or difficulty breathing ☐ Yes ☐ No
   - Fever of 100°F or greater ☐ Yes ☐ No
   - New or worsening headaches ☐ Yes ☐ No
   - Sore throat ☐ Yes ☐ No
   - New loss of taste or smell ☐ Yes ☐ No
   - Excessive/persistent runny nose ☐ Yes ☐ No
   - Vomiting ☐ Yes ☐ No
   - Diarrhea ☐ Yes ☐ No

   Please refer to the ECEP Parent Handbook for additional symptoms that may exclude your child from care.

NOTES:

Child’s temperature upon arrival is: _______________

Child’s temperature at midday is: _______________ (to be taken by Teacher)

I understand that if I answer yes to any of the above questions and/or my child exhibits one or more of the above listed symptoms at any point in the day my child will not be able to return to the center until:

1. The child has remained home for at least 10 days since symptoms first appeared, AND there have been at least 24 hours with no fever, without the aid of taking medicines to lower the fever, such as acetaminophen (Tylenol) or ibuprofen (Advil or Motrin), AND other symptoms (such as cough or shortness of breath, are improving), OR

2. My child’s symptoms have resolved AND the child has been evaluated by a medical professional (a doctor, a nurse practitioner, or a certified physician assistant), and provides a letter indicating that (1) an alternative diagnosis has been made and (2) the child’s symptoms are most likely NOT due to COVID-19, OR

3. The child has received a NEGATIVE COVID-19 test, AND the child is feeling better, AND there have been at least 24 hours with no fever, without the aid of taking medicines to lower the fever, such as acetaminophen (Tylenol) or ibuprofen (Advil or Motrin), AND the child has consulted a medical professional (a doctor, a nurse practitioner, or a certified physician assistant) to determine the significance of their symptoms. The medical evaluator will need to provide a letter indicating that (1) the child’s symptoms are most likely NOT due to COVID-19, and (2) the COVID-19 test was negative.

Parent’s Name (please print): ____________________________________________ Date: _________________________

Parent’s Signature: ________________________________________________________

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