

**Vista Autism Services
COVID-19 Health Monitoring Checklist**

Name of Symptomatic Individual										
Type of Individual (Staff, Client, Other)	Staff	Client	Other							
Vista Program	EIBI	School/EIBS	VASO Employment	VASO CIC	VASO In-Home	Outreach	CoVE	Other		
Date and Time of Incident	Date:			Time:						
Name of Person Completing Form (Print)										

Please complete the following checklist when concerned for possible sickness similar to symptoms of COVID-19:

Yes	No	Symptom
Yes: proceed to isolation procedures	No: continue down checklist	Temperature greater than 100?
Yes: proceed to isolation procedures	No: continue down checklist	Persistent and productive cough?
Yes: proceed to isolation procedures	No: continue down checklist	Shortness of breath along with a persistent and productive cough AND/OR a fever?
Yes: monitor	No: follow internal sick policy/protocol as applicable	Shortness of breath
Yes: monitor	No: follow internal sick policy/protocol as applicable	Chills
Yes: monitor	No: follow internal sick policy/protocol as applicable	Fatigue
Yes: monitor	No: follow internal sick policy/protocol as applicable	Body aches
Yes: monitor	No: follow internal sick policy/protocol as applicable	Headache
Yes: monitor	No: follow internal sick policy/protocol as applicable	New loss of taste or smell
Yes: monitor	No: follow internal sick policy/protocol as applicable	Sore throat
Yes: monitor	No: follow internal sick policy/protocol as applicable	Congestion or runny nose
Yes: monitor	No: follow internal sick policy/protocol as applicable	Nausea or vomiting
Yes: monitor	No: follow internal sick policy/protocol as applicable	Diarrhea
Yes: proceed to isolation procedures	No: monitor individual	Does the individual have three or more non red symptoms?

Please complete the following checklist when concerned for possible sickness similar to symptoms of MIS-C:

Yes	No	Symptom
Yes: proceed to isolation procedures	No: follow internal sick policy/protocol as applicable	Temperature greater than 100
Yes: proceed to isolation procedures	No: follow internal sick policy/protocol as applicable	Severe abdominal pain
Yes: proceed to isolation procedures	No: follow internal sick policy/protocol as applicable	Pain or pressure in chest that does not go away
Yes: proceed to isolation procedures	No: follow internal sick policy/protocol as applicable	Bluish lips or face
Yes: proceed to isolation procedures	No: follow internal sick policy/protocol as applicable	Inability to wake or stay awake
Yes: monitor	No: follow internal sick policy/protocol as applicable	New confusion
Yes: monitor	No: follow internal sick policy/protocol as applicable	Vomiting
Yes: monitor	No: follow internal sick policy/protocol as applicable	Diarrhea
Yes: monitor	No: follow internal sick policy/protocol as applicable	Neck pain
Yes: monitor	No: follow internal sick policy/protocol as applicable	Rash
Yes: monitor	No: follow internal sick policy/protocol as applicable	Bloodshot eyes
Yes: monitor	No: follow internal sick policy/protocol as applicable	Fatigue
Yes: proceed to isolation procedures	No: monitor individual	Does the individual have three or more non red symptoms?

Parent/Guardian Directions:

Please follow the directions that are checked off below. If consulting a medical professional, please share the above symptom checklist.

 Your son/daughter had symptoms similar to COVID-19 or MIS-C, and following our assessment above, adhered to our standard internal 'illness/sick practices.' **Your son/daughter DID NOT need to use the isolation area.** Please continue to monitor your son/daughter carefully and if you feel necessary, have your son/daughter assessed further by a medical professional. **There is no further documentation or criteria needed for your son/daughter to return.**

 Your son/daughter had symptoms similar to COVID-19 or MIS-C, and following our assessment above, adhered to our standard internal 'illness/sick practices.' **Your son/daughter DID NOT need to use the isolation area.** However, your child did have either vomiting or diarrhea to the extent that requires your son/daughter to be symptom free for 24 hours before returning to the program. Please continue to monitor your son/daughter carefully and if you feel necessary, have your son/daughter assessed further by a medical professional. **Please follow the 24 -hour policy as we will not be able to accept your son/daughter prior.**

 Your son/daughter had symptoms similar to COVID-19 or MIS-C, and following our assessment above, **was sent to the Isolation Area.** Please continue to monitor your child carefully and if you feel necessary, have your son/daughter assessed further by a medical professional. Your child had 3 or more symptoms and that requires your son/daughter to be symptom free for 24 hours before returning to the program. **Please follow this 24 -hour policy as we will not be able to accept your son/daughter prior to that timeline.**

 Your son/daughter had symptom(s) similar to COVID-19 or MIS-C and, following our screening assessment above, **was sent to the Isolation Area.** **Please contact a medical professional to have your son/daughter further evaluated. A doctor note and adherence to the 24-hour policy is required prior to your son/daughter returning.** If the doctor recommends further assessment/COVID-19 testing, your son/daughter may not return until one of two conditions occur: 1) A negative test result is produced and shared with Vista AND your child is symptom free for 24 hours without the aid of medication; 2) A positive test result is produced. In this case, please contact Vista immediately, as well as the Department of Health at 1-877-724-3258. **Your son/daughter will need to remain out of Vista programs until the 11th day from the onset of symptoms as well as until they are symptom free for at least 24 hours without the aid of medication.**