生病学生通知

Student Name: _____ Date:_____

School:_____ Time:_____ AM/PM

家长/监护人：

医务室今天发现您的孩子出现以下无法解释的新症状：

☐Fever/chills/发烧/发冷 ☐Cough/咳嗽 ☐Shortness of breath/呼吸急促 ☐New loss of taste/smell/新的味觉/嗅觉损失症状

Temp/体温：_____

☐Sore throat/喉咙疼 ☐Fatigue/疲劳 ☐Muscle aches/肌肉疼痛 ☐Runny nose/congestion/流鼻涕/鼻塞

☐Stomachache/胃痛 ☐Diarrhea/腹泻 ☐Nausea/vomiting/恶心/呕吐 ☐Headaches/头痛

☐Other/其他: _____

鉴于本社区存在 *COVID-19* 病例，医疗保健提供者建议所有生病儿童接受评估。请将此表带给您的医疗保健提供者。

School Public Health Nurse/Aide Observation/ 学校公共卫生护士/助理观察员：

Comments/意见: _____

_____

签名：_____ 注册护士 *(RN)* /保健员

请遵循下方的返回学校指导，如果您的孩子因上述任何症状而被送回家：

如果没有与 COVID-19 病例密切接触：

- **COVID-19 测试呈阳性** – 请自出现症状，同时在未服用退烧药的前提下退烧达 24 小时并且症状有所缓解后的 ***10*** 天内；或若无任何症状，则自检测呈阳性之日起的 ***10*** 天内待在家中。
- **COVID-19 测试呈阴性 –** 请在未服用退烧药的前提下退烧达 24 小时并且症状有所缓解之前待在家中。
- **未接受测试且无其他诊断 –**自出现症状，同时在未服用退烧药的前提下退烧达 24 小时并且症状有所缓解后的 ***10*** 天 内进行居家隔离。
- **医疗保健提供者对症状进行解释的其他诊断 –** 请在未服用退烧药的前提下退烧达 24 小时并且症状有所缓解之前待在家中，或是根据医疗保健提供者的指示行事。

如果与 COVID-19 病例密切接触：

- **COVID-19 测试呈阳性 –** 请自出现症状，同时在未服用退烧药的前提下退烧达 24 小时并且症状有所缓解后的 ***10*** 天；或若无任何症状，则自检测呈阳性之日起的 ***10*** 天内待在家中。
- **测试结果呈阴性或未接受 COVID-19 测试：** – 请自上一次接触病毒，同时在未服用退烧药的前提下退烧达 24 小时并且症状有所缓解后的 ***14*** 天内待在家中进行隔离。

www.fairfaxcounty.gov/health/novel-coronavirus

703-267-3511, TTY 711

Chinese-Simplified

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Permission to Return to School/Child Care

Dear provider:

Please assess children with illness symptoms or COVID-19 exposure using the VDH Algorithm for Evaluating a Child with COVID-19 Symptoms or Exposure (https://www.vdh.virginia.gov/content/uploads/sites/182/2020/08/Evaluating-Symptoms-in-a-Child.pdf). Testing for SARS-CoV-2 is strongly recommended for all children who present any symptom of COVID-19 unless their history and clinical presentation is entirely consistent with a condition the child is known to have (e.g., allergies, asthma, migraine). Because children may have co-infections with SARS-CoV-2 and other pathogens, testing is encouraged even if another etiology is identified.

Patient Name: _____ Date of Visit: _____

Date of Most Recent Exposure *(if applicable)*: _____ Date of Test *(if applicable)*: _____

Date of First Symptoms *(if applicable)*: _____

Check all that apply:

☐ I have assessed the child consistent with the VDH COVID-19 algorithm and provided recommendations consistent with the **Return to School guidance** (located in the blue box on the reverse side of this document)

☐ No communicable disease has been identified, including COVID-19, based on:

- ☐ Laboratory test results
- ☐ An alternate, non-communicable diagnosis

The earliest date this patient may return to school is _____. This statement is valid based on current relevant information but may change based on new symptoms, exposures, or results. The patient's family has been instructed to notify the office for any changes.

Signature: _____MD/DO/NP/PA/RN/LPN Phone #: _____

Name: _____

References/Resources:

- For the current list of symptoms: www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html
- VDH Algorithm for assessing children: www.vdh.virginia.gov/content/uploads/sites/182/2020/08/Evaluating-Symptoms-in-a-Child.pdf
- Return to School Guidance form: http://bit.ly/FairfaxCOVIDChildForm