RITE OF PASSAGE
IMPROVING THE LIVES OF YOUTH

COVID-19 Student Discharge Screening Tool

Student Name: _____ ***Discharge Date:*** _____

Discharge Screening: To Be Completed by Medical Staff

	YES	NO
Has the student had a cough or shortness of breath within the past 10 days?	☐	☐
Has the student had pneumonia or the flu within the past 10 days?	☐	☐
Has the student had a fever greater than 100° F within the past 10 days?	☐	☐
Has the student had contact with anyone who has lab-confirmed Coronavirus within 10 days of symptom onset?	☐	☐
Has the student been tested for COVID-19?	☐	☐

If yes: **Date of test:** _____ **Results:** _____

STUDENT VITAL SIGNS:

Temperature _____

Heart Rate _____

Blood Pressure _____

Screening Staff Printed Name: _____ **Screening Staff Signature:** _____

Supervisor Printed Name: _____ **Supervisor Signature:** _____

Comments: _____

_____

_____

(Copy of completed form to be filed in student medical file)