COVID-19 Assessment

Individual Name: _____ Date Completed: _____
Date(s) of **Positive** COVID Test(s): _____
Date(s) of **Negative** COVID Test(s): _____
Post COVID+ Determination Date: _____

Is there an antibody test on file? ☐ Yes ☐ No If Yes: ☐ Positive ☐ Negative

Is the individual currently displaying any symptoms of COVID 19 (i.e. fever above 100.4 without fever reducing medication, cough, difficulty breathing or swallowing, vomiting, diarrhea)? ☐ Yes ☐ No

All Guardians/Individuals collective consent to visitors entering their home? ☐ Yes ☐ No

All Guardians/Individuals collective consent to visits outside of the home? ☐ Yes ☐ No

Is the individual competitively employed in the community? ☐ Yes ☐ No

General Risk Areas	High Risk	Medium Risk	Low/No Risk
Age: _____	☐ 65+	☐ 35-64	☐ 34 and younger
Has practiced and can tolerate wearing a mask	☐ No	☐ Sometimes	☐ Yes
Has practiced social distancing	☐ No	☐ Sometimes	☐ Yes
Has tested negative immediately prior to returning ***Only answer this question if the individual is returning to the CRS/CLA/ICF***	☐ No		☐ Yes
Requires physical assistance in ADLs and/or hands on behavior interventions.	☐ Yes	☐ Sometimes	☐ No
Medical Conditions (per CDC)	**High Risk**	**Medium Risk**	**Low/No Risk**
Diabetes	☐ Yes		☐ No
Immunocompromised (including cancer and treatment, i.e., chemo and radiation, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications)	☐ Yes		☐ No
Chronic lung disease or moderate to severe asthma	☐ Yes		☐ No
Serious Heart Condition	☐ Yes		☐ No
Severe Obesity (BMI of 40 or higher)	☐ Yes		☐ No
Chronic kidney disease undergoing dialysis	☐ Yes		☐ No
Liver Disease	☐ Yes		☐ No

Total Number of Responses
of High Risk: _____
of Medium Risk: _____
of Low/No Risk: _____

Completed By/Title: _____ Signature: _____

6-4-20