



INTERNATIONAL TRAVEL SCREENING FORM FOR SCHOOLS

DATE: _____

STUDENT INFORMATION:

Name: _____ DOB: _____

Address: _____ Gender: Male OR Female

Student ID#: _____

Parent's Name: _____ Parent's Phone Number: _____

TRAVEL HISTORY:

Have you traveled outside of the U.S. in the past 30 days? YES NO

If YES, what countries and when?

Date Arrived in US: _____

Country #1: _____

Dates in Country #1: _____ to _____

Country #2: _____

Dates in Country #2: _____ to _____

Country #3: _____

Dates in Country #3: _____ to _____

SYMPTOM HISTORY:

Have you developed any of the following symptoms since returning to the US?

Fever Onset Date: _____

Cough Onset Date: _____

Difficulty Breathing Onset Date: _____

Sore Throat Onset Date: _____

Chills Onset Date: _____

Headache Onset Date: _____

Muscle Aches Onset Date: _____

Vomiting Onset Date: _____

Diarrhea Onset Date: _____

Any Other Symptoms: _____

No Symptoms

EXPOSURE HISTORY:

1. Have you been around or know of anyone who is confirmed with or under investigation for 2019-nCoV? YES NO
If YES, who and when? _____

Cleared to return to class

Evaluate for other illness

If YES to **BOTH** International Travel and Symptoms:

1. Isolate the student in a private room
2. Provide the student with a facemask
3. Wear an N95 Respirator (Nurse)
4. Contact Dallas County Health and Human Services at (214) 819-2004.