CP Nassau's Health Assessment Screening Form

Name: Date:

1. Do you or did you have any of the following symptoms during the past 14 days?

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Nausea or vomiting
- Congestion or runny nose
- Sore throat
- Diarrhea
- Headache
- Loss of taste or smell

Yes	No

If you have any of these symptoms, you may not enter the building. Please return to your car and contact your supervisor immediately.

2. Have you, or someone close to you, had a positive COVID test during the past 14 days?

Yes	No

If yes, you may not enter the building. Please return to your car and contact your supervisor immediately.

3. Have you, or someone close to you, been in contact with a person known to have the Corona virus in the past 14 days?

Yes	No

If yes, you may not enter the building. Please return to your car and contact your supervisor immediately.

4. Have you traveled outside of New York State within the past 14 days?

Yes	No

If yes, you may not enter the building. Please return to your car and contact your supervisor immediately.

5. Have you had visitors who traveled from outside of New York State to New York State within the past 14 days?

Yes	No

If yes, you may not enter the building. Please return to your car and contact your supervisor immediately.

Cell phone number where you can be reached: _____

Signature: _____

6. Does the person have a temperature of 100 degrees or over?
   Yes No

To Receiver: If yes, please inform the person that they may not enter the building. Instruct them to return to their car and contact their supervisor immediately.

Cell phone number where person can be reached:

_____

Receiver Signature: _____ Date: _____

Formulario De Examen De Evaluación De La Salud Del CP Nassau

Nombre: Fecha:

1. ¿Tiene usted o alguno de los siguientes síntomas durante los últimos 14 días?

- Fiebre o escalofríos
- Tos
- Corta Respiracion
- Fatiga
- Dolores musculares o corporales
- Náuseas o vómitos
- Congestión nasal o nariz mocosa
- Dolor de garganta
- Diarrea
- Dolor de cabeza
- Pérdida del gusto u olor

Sí	No

Si usted tiene cualquiera de estos síntomas, no puede entrar en el edificio. Por favor, vuelva a su coche y póngase en contacto con su supervisor inmediatamente.

2. ¿Usted, o alguien cercano, ha tenido una prueba COVID positiva durante los últimos 14 días?

Sí	No

En caso afirmativo, no puede entrar en el edificio. Por favor, vuelva a su coche y póngase en contacto con su supervisor inmediatamente.

3. ¿Usted, o alguien cercano a usted, ha estado en contacto con una persona que se sabe que tiene el virus Corona en los últimos 14 días?

Sí	No

En caso afirmativo, no puede entrar en el edificio. Por favor, vuelva a su coche y póngase en contacto con su supervisor inmediatamente.

4. ¿Ha viajado fuera del estado de Nueva York en los últimos 14 días?

Sí	No

En caso afirmativo, no puede entrar en el edificio. Por favor, vuelva a su coche y póngase en contacto con su supervisor inmediatamente.

5. ¿Ha tenido visitantes que viajaron desde fuera del estado de Nueva York al estado de Nueva York en los últimos 14 días?

Sí	No

En caso afirmativo, no puede entrar en el edificio. Por favor, vuelva a su coche y póngase en contacto con su supervisor inmediatamente.
Número de teléfono celular donde se puede contactar: _____
Firma:
_____

6. ¿Tiene la persona una temperatura de 100 grados o más?

Sí No

Para el receptor: En caso afirmativo, informe a la persona que no puede entrar en el edificio. Indíqueles que regresen a su coche y se ponga en contacto con su supervisor inmediatamente.

Número de teléfono celular donde se puede contactar a la persona:

_____

Firma del receptor: _____ **Fetcha:** _____

STAFF SICK FORM - ADDRESS IMMEDIATELY
CP Nassau's Health Assessment Screening Form

Name: Date:

Staff person answered "Yes" to the following question(s):

1. Do you or did you have any of the following symptoms during the past 14 days?

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Nausea or vomiting
- Congestion or runny nose
- Sore throat
- Diarrhea
- Headache
- Loss of taste or smell

Yes	No

2. Have you, or someone close to you, had a positive COVID-19 test during the past 14 days?

Yes	No

3. Have you, or someone close to you, been in contact with a person known to have the COVID-19 in the past 14 days?

Yes	No

4. Have you traveled outside of New York State within the past 14 days?

Yes	No
If yes, where?	

5. Temperature 100 degrees or over

_____

(Record the actual Temperature)

6. Staff person sent back to their car:

Yes	No

Cell phone number where staff can be reached: _____

Screener Signature: _____ Date: _____

Instructions:

- Complete Form and give immediately to Supervisor on Duty
- Supervisor on Duty will immediately forward to Director of Nursing (Center/Bayville) Coordinator of Health Care Services (Residential)
    - In Residential, if there is no Supervisor on Duty, contact Coordinator of Health Care Services immediately.

PROGRAM PARTICIPANT SICK FORM - ADDRESS IMMEDIATELY
CP Nassau's Health Assessment Screening Form

Name: Date:

Staff person answered "Yes" to the following question(s):

1. Do you or did you have any of the following symptoms during the past 14 days?

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Nausea or vomiting
- Congestion or runny nose
- Sore throat
- Diarrhea
- Headache
- Loss of taste or smell

Yes	No

2. Have you, or someone close to you, had a positive COVID-19 test during the past 14 days?

Yes	No

3. Have you, or someone close to you, been in contact with a person known to have the COVID-19 in the past 14 days?

Yes	No

4. Have you traveled outside of New York State within the past 14 days?

Yes	No

If yes, where?

5. Temperature 100 degrees or over _____
(Record the actual Temperature)

6. Symptoms: _____

_____

Receiver Signature: _____ Date: _____

Instructions:

- Complete Form and give immediately to Supervisor on Duty
- Supervisor on Duty will immediately forward to Director of Nursing (Center/Bayville) Coordinator of Health Care Services (Residential)
    - In Residential, if there is no Supervisor on Duty, contact Coordinator of Health Care Services immediately.

Cerebral Palsy Association of Nassau County
380 Washington Avenue, Roosevelt, New York 11575

COVID-19 RETURN TO WORK - FITNESS FOR DUTY CERTIFICATION

This form must be completed by staff who have a temperature of 100 degree or over, exhibited symptoms of COVID-19, have been diagnosed with COVID-19 or were exposed to coronavirus/COVID-19.

When your physician releases you from care, you will be required to deliver this certificate to your supervisor, by mail or email, 1-2 business days prior to your planned return to work date.

Failure to submit this form may delay your return to work.

SECTION 1 to be completed by Employee:

Name: _____ Department: _____

Date Leave Began: _____ Date of Planned Return: _____

_____ _____
Employee's Signature Date

SECTION 2 to be completed by Health Care Provider:

I have examined the above-named employee of the Cerebral Palsy Association of Nassau County. I certify that this employee is fit to return to work, as follows:

____ Fully duty with no restrictions.

____ With restrictions as noted below:

Restrictions: _____

Restrictions must be in place until _____
Date

_____ _____
Health Care Provider's Signature Date

_____ _____
Health Care Provider's Name (printed) Date

Cerebral Palsy Association of Nassau County
380 Washington Avenue, Roosevelt, New York 11575

COVID-19 RETURN TO PROGRAM
FOR PROGRAM PARTICIPANTS

This form must be completed by Health Care Provider for any individual who has a temperature of 100 degrees or over, exhibited signs or symptoms of COVID-19, have been diagnosed with COVID-19 or were exposed to COVID-19.

Name: **Date:**

I have examined the above named individual who attends day program at Cerebral Palsy Association of Nassau County.

Covid-19 Test:

Yes Result: _____ Date: _____

☐

No

☐

The above named individual is able to return to program, as follows:

☐ Cleared to return without restrictions

Date of return: _____

☐ With restrictions as noted below:

Restrictions:

Restrictions must be in place until: _____ (Date)

Health Care Provider's Signature: Date:

Health Care Provider's Stamp:

Cerebral Palsy Association of Nassau County
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COVID-19 REGRESO AL PROGRAMA
PARA LOS PARTICIPANTES DEL PROGRAMA

Este formulario debe ser completado por el proveedor de atención médica para cualquier persona que tenga una temperatura de 100 grados o más, presente signos o síntomas de COVID-19, haya sido diagnosticado con COVID-19 o haya estado expuesto a COVID-19.

Nombre: **Fecha:** _____

He examinado a la persona mencionada anteriormente que asiste al programa de día en la Asociación de Parálisis Cerebral del Condado de Nassau.

Prueba Covid-19:

Si ☐ Resultado: _____ Fecha: _____

No ☐

El individuo mencionado anteriormente es capaz de volver al programa, de la siguiente manera:

☐ Despejado para regresar sin restricciones

Fecha de devolución: _____

☐ Con restricciones como se indica a continuación:

Restricciones:

Las restricciones deben estar en su lugar hasta: _____ (Fecha)

Firma del proveedor de atención médica: Fecha:

Sello del proveedor de atención médica:

Health Care Provider's Stamp:

Cerebral Palsy Association of Nassau County
380 Washington Avenue
Roosevelt, New York 11575

Day Hab Monthly Transport Mileage Reimbursement

For the Month of: _____

Name: _____

Home Address: _____

Individuals Name: _____

2020 Mileage Rate Reimbursement 57.5 Cents Per Mile (January 2020)

DATE	DESTINATION	MILEAGE (round trip)

	Mileage Total	
	Reimbursement Total @$57.5 per mile	

Department Code: _____
Approval: _____
Date: _____