V. 07/10/21

DALLAS COUNTY HEALTH AND HUMAN SERVICES

COVID-19 Positive Case Report Form

for Daycare, After School Program and Camp

Facility Information

Program Name:		**Facility Name & Address:**	
Director Name:		**Total # Staff:**	
		Total # Children Enrolled:	
Director Phone:		**Date Program Notified of Positive Case:**	___/___/_____
Director Email:			

Positive Case Information

Last Name: **First Name:** **MI:** **DOB:** ___/___/_____

Sex: □ Female □ Male □ Non-binary **If female, pregnant?** □ Yes – pregnant □ No □ N/A

Race: □ White □ Black □ Native American □ Asian/ Pacific Islander □ Other

Ethnicity: □ Hispanic □ Non-Hispanic □ Unknown **Parent/Guardian Name:**

Address: **Parent/Guardian Contact** Phone:

Email:

Case's Role in the Program: □ Attendee (i.e. camper, student) □ Teacher/Counselor □ Admin/Support ☐ Other _____

Class/Cohort/Group(s): □ Indoor □ Outdoor

# of staff in affected group/class(es): # of attendees in affected group/class(es):

Program Start Date (if applicable): Program End Date (if applicable):

Clinical Case History

Was/is the individual symptomatic? □ Yes □ No

If yes, **date of 1st symptom**: ___/___/_____

Symptoms (please check all that apply): □ N/A (no symptoms)

□ Abdominal pain □ Fatigue □ Runny nose
□ Body aches □ Fever: ____ °F □ Shortness of breath
□ Congestion □ Headache □ Sore throat
□ Cough □ Loss of smell/taste □ Vomiting
□ Diarrhea □ Nausea □ Other: _____

Last Date at Facility: ___/___/_____

Return Date*: ___/___/_____

Pre-existing medical conditions? □ Yes □ No

□ Asthma/COPD (circle one) ☐ Other _____
□ Diabetes _____
□ High Blood Pressure _____
□ Obesity _____

Has he/she completed the Covid-19 vaccine? □ Yes □ No

If yes,
Type of Vaccine received: □ Janssen □ Moderna □ Pfizer

Date received: Dose 1: ___/___/_____ Dose 2: ___/___/_____

Exposure Assessment/Contact Tracing:

Does the individual know how they were exposed to Covid-19? □ Yes □ No

If yes, **please describe:**

How many program close contacts identified?** _____

How many non-program close contacts identified?** _____

Return date for close contacts*** who are also program attendees: ___/___/_____

Diagnostic Testing Information

Type of Test	Name and Address of Testing Location:	Date of Specimen Collection:	Copy of Lab Attached?
○ PCR ○ Antigen		___/___/_____	□ Yes □ No If no, please obtain a copy to include with this form or send lab copy ASAP

Report summary / notes / vaccine information:

If applicable, please attach the following:

□ A list of known extracurricular involvements and names of other daycares/camps/schools/after school programs attended

□ A list of all known close contacts, including names of siblings, classmates, and staff members

Please fill out this form in its entirety to the best of your knowledge and send it to Dallas County Health Department via secure email to DaycareOutbreaks@DallasCounty.org.

*Isolation ends 10 days after the date of first symptoms or the positive test date if asymptomatic.

**Within 6 feet of an infected person for a total of 15 minutes starting from 48 hours before the person was first symptomatic or tested positive until the time the patient was isolated.

***Dallas County recommends a 14 day quarantine from last date of contact with a COVID-19 PCR or Antigen lab confirmed case.