PASADENA
PUBLIC HEALTH DEPARTMENT

Incident ID (to be completed by PPHD):

COVID-19 Exposure Investigation Worksheet for the Eduction Sector

(Early Childhood Education, K-12 Schools, & Institutes of Higher Education)

Instructions: Use this form to guide preliminary investigations of confirmed COVID-19 cases in the Educational Setting to inform follow-up action for prevent further COVID-19 transmission.

Investigator's Name: _____ Date Interviewed: _____ Contact Info: _____

A case is considered to be infectious starting from 48 hours before symptom onset (or from the test date if no symptoms) until 10 days have passed since symptom onset (or test date) AND 1 day with no fever and improved respiratory symptoms, whichever is longer.

Section 1 Case Demographics

Last Name	First Name	Date of Birth	Age

Patient's current gender identity? ☐ Male ☐ Female ☐ Female-to-Male (FTM)/Transgender MA ☐ Male-to-Female (MTF)/Transgender FE
☐ Gender Non-Binary, Gender Non-Conforming ☐ Other: _____ ☐ Prefer not to state ☐ Unknown

Patient's sex at birth? ☐ Male ☐ Female ☐ Non-binary or X ☐ Other: _____ ☐ Prefer not to state

Hispanic or Latino? ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Refused ☐ Unknown

Race ☐ White ☐ Black/African-American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander
☐ Other: _____ ☐ Refused ☐ Unknown

Sexual Orientation ☐ Gay or Lesbian ☐ Bisexual ☐ Straight or Heterosexual ☐ Not Sure ☐ Something Else: _____
☐ Don't understand the question ☐ Prefer not to state

Role ☐ Student ☐ Staff Teacher/Faculty ☐ Staff Healthcare Worker ☐ Staff Public Safety
☐ Staff Other: _____ ☐ Visitor ☐ Other:_____

If Healthcare Worker, Specify facility name(s) and address.
Job Title: _____

Last day worked. _____ Did you work while symptomatic? ☐ Yes ☐ No ☐Unknown
Do you have direct patient contact? ☐ Yes ☐ No ☐ Unk
In the 14 days prior to illness onset, did you have contact with anyone diagnosed with Covid-19? ☐ Yes ☐ No ☐Unknown
If yes, Was this person a healthcare worker or patient at your facility? ☐ Yes ☐ No ☐Unknown

Education Group Cohort ☐ Academic Class ☐ Campus Residential ☐ Off Campus Residential ☐ Social Organization ☐Sport or Recreation
☐ Workplace ☐ Other Specify: _____
Name of Group: _____

Patient's Address: Number, Street, Apt #		City	State	Zip
Is this the permanent address? ☐ Yes ☐ No ☐ Unknown	If above not permanent address, specify.	City	State	Zip

Home Phone Number	Cell Phone Number	Email Address

If patient's age is under 18, Parent/Guardian Last Name	Parent/Guardian First Name		
Guardian Address	City	State	Zip

Home Phone Number	Cell Phone Number	Email Address

Section 2 CASE INFORMATION

Was the individual tested for COVID-19?	☐ Yes	☐ No	Date Tested: Test Result: ☐ Positive ☐ Presumptive Positive ☐ Inconclusive ☐ Other Specify: _____
Is this individual in isolation?	☐ Yes	☐ No	Start Date of Isolation:
Where is the isolation location?	☐On Campus Isolation Housing ☐ Dorm Room ☐ On Campus Apartment ☐ Off Campus Apartment/House ☐ Returned home ☐ Other Specify: _____		

Section 3 LOCATION INFORMATION

Educational setting identifies as:	☐ Early Childhood Education (ECE) ☐ K to 12; Grade ☐ K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ Institute of Higher Education (IHE) ☐ Other Specify: _____ Specify Institution Name: _____
Dates in Educational Setting while Infectious	Date:
Locations in Educational Setting while Infectious (i.e., Building/Wing/Floor/Room)	Please Specify here:

Please Submit Form to nursing@cityofpasadena.net

Draft Date: 7/24/2020

Case Last Name:_____ Case First Name:_____ ID#_____

Section 4 SYMPTOMS AND CLINICAL HISTORY

Do you currently have, or did you have symptoms? ☐ Yes, onset date: _____ ☐ No ☐ Unknown ☐ Refused

Symptoms (check all that apply) ☐ Fever (>100.4 ºF/38 ºC)? High temp _____ Unit ☐ ºF ☐ ºC ☐ Subjective Fever

Date Fever Onset: _____ Duration (days): _____

☐ Cough ☐ Shortness of breath ☐ Muscle Aches ☐ Sore throat ☐ Diarrhea ☐ Chills ☐ Vomiting ☐ Runny nose

☐ Headache ☐ Abdominal pain ☐ Loss of smell ☐ Loss of taste ☐ Other:_____

Do you have an underlying health condition such heart disease, lung disease, diabetes, kidney disease, or weakened immune system? ☐ Yes ☐ No ☐ Unk

If yes, say: "it is important for you to contact your healthcare provider and speak with them since you are at higher risk for serious illness from COVID-19."

If yes, specify: _____

If yes, do you have a healthcare provider who helps you manage your health condition? ☐ Yes ☐ No ☐ Unk

Section 5 EXPOSURE HISTORY

In the 14 DAYS prior to symptom onset (or date of test if asymptomatic):	Yes	No	Date Range	Notes
…did you go to the school/campus?	☐	☐		If yes, describe environment
-...did you travel?	☐	☐		If yes, describe where and mode of travel
…have any household members, friends, acquaintances, or co-workers who had symptoms?	☐	☐		If yes, please collect information on contact name, phone number, address, email
…have close contact (e.g. caring for, speaking with, or touching) with any ill persons?	☐	☐		If yes, please collect information on contact name, phone number, address, email
…attend a mass gathering (e.g., protests, religious event, wedding, party, dance, concert, banquet, festival, sports event, or other event) where it was difficult to practice social distancing?	☐	☐		Record when, where, and who you were with
…have close contact with a person who had lab-confirmed COVID-19	☐	☐		If yes, please collect information on contact name, phone number, address; relationship with case, and the case's positive test date, if known.

Section 6 Places and Possible Contacts during Infectious Period

Daily Diary

If symptomatic: from 2 days prior to symptom onset in case-patient: MM/DD/YYYY through today
If no symptoms: from 2 days prior to test date in case-patient: MM/DD/YYYY through today

I would like to ask you some questions about what you've done daily from two days before you started feeling sick (or if no symptoms, from two days before you got tested) and today.

Case Last Name:_____ Case First Name:_____ ID#_____

Section 6.1	Possible Household Contacts		
Now I would like to ask you more about your possible contacts during the time you may have been infectious. For these contacts, we request that you provide information on names of these contacts, dates of their possible exposures, and information on how we can get in touch with them (e.g., address, phone number, email address) to communicate important public health messages to prevent further transmission of disease.			
			If yes, please collect information on contact name, phone number, address, email
Has anyone else spent time at your home (eating meals, hanging out, sleeping over, babysitting) but doesn't live with you?	☐ Yes	☐ No	
Has anyone taken care or cleaned up after you?	☐ Yes	☐ No	
Has anyone slept in the same room with you?	☐ Yes	☐ No	
Do you have an intimate partner who lives with you?	☐ Yes	☐ No	
Do you live with anyone else? (roommates, family members, etc)	☐ Yes	☐ No	
Section 6.2	**Possible Close Contacts**		
Did you have close physical contact (e.g. hugging, kissing, shaking hands with) with anyone other than your household members?	☐ Yes	☐ No	
Have you eaten or shared a meal with anyone? (e.g. at a friend's house, during a social outing or with coworkers?)	☐ Yes	☐ No	
Have you shared a cigarette, e-cigarette, vape-pen, hookahs, and water pipes with anyone?	☐ Yes	☐ No	
Section 6.3	**Possible Transportation Contacts**		
What modes of transportation have you used during the time you may have been infectious?	☐ Personal vehicle ☐ Airplane ☐ Bus ☐ Shuttle ☐ Train ☐ Rideshare/Taxi ☐ Other:___ *Describe transportation:* _____ *If Rideshare provide license plate #:* _____ *If Airplane/Train provide flight and seat #:* _____		
Did you spend more than 15 minutes in the same mode of transportation with anyone?	☐ Yes	☐ No	
Section 6.4	**Possible Work or Volunteering Contacts**		
Is there anyone at work you were within 6 feet of for more than 15 minutes? (i.e. work meetings, shared office)	☐ Yes	☐ No	
Did you volunteer anywhere?	☐ Yes	☐ No	*Describe activities* Volunteer dates: Facility name: _____ Facility address: _____ Facility phone #: _____ Name of person to contact: _____
Section 7	**Remarks**		