In accordance with recent CDC guidelines, this healthcare facility is screening all patients prior to entering the treatment area for COVID-19.

Child's Name ______________________________

Have you, your child, or others accompanying you to today's appointment or other recent acquaintances **tested positive** for or been diagnosed as having **COVID-19** or any other **communicable disease**?*

❏ Y
❏ N

If yes, has your doctor cleared that individual to go back out in the general public?

❏ Y
❏ N

Do you, your child, others accompanying you to today's appointment or other recent acquaintances have persistent **pain, pressure, or tightness in the chest**?*

❏ Y
❏ N

Do you, your child, others accompanying you to today's appointment or other recent acquaintances have a **cough**?*

❏ Y
❏ N

Do you, your child, others accompanying you to today's appointment or other recent acquaintances have a **sore throat, shortness of breath and/or trouble breathing**?*

❏ Y
❏ N

Have you, your child, others accompanying you to today's appointment or other recent acquaintances recently **lost their sense of smell or taste**?

❏ Y
❏ N

Do you, your child, others accompanying you to today's appointment or other recent acquaintances have any **GI symptoms**? **Diarrhea**? **Nausea**?

❏ Y
❏ N

Do you, your child, others accompanying you to today's appointment or other recent acquaintances have a **fever** (defined as **above 99.6 degrees** without medication)?*

❏ Y
❏ N

Have you, your child, others accompanying you to today's appointment **been in contact** with someone who has **tested positive for COVID-19 in the last 14 days**?

❏ Y
❏ N

Parent/Guardian Signature ______________________________ Date ________________