

COVID-19 Screening Questions:

Please circle yes or no pertaining to the following questions.

1. Are you or your child currently having or over the past 14 days, have you experienced fever, body aches, or signs of respiratory illnesses such as worsening cough, fatigue, or shortness of breath?

YES

NO

2. Are you or your child currently having or over the past 14 days, have you experienced any symptoms of consistent cough, runny nose, congestion, sore throat, headaches, or general fatigue?

YES

NO

3. Have you or a close contact traveled out of the country, been to an airport, or have been aboard a cruise ship in the last 14 days?

Close contact is defined as:

a. Being within 6 feet (2 meters) of a suspected COVID-19 case for a prolonged period of time.

b. Caring for, having meals with, living with, visiting, or sharing a healthcare waiting area/room.

c. Having direct contact with secretions of a COVID-19 case (eg, being coughed on)

YES

NO

If you answer 'yes' to any of these questions:

**YOUR CHILD IS NOT PERMITTED TO BE SEEN.
PLEASE RESCHEDULE APPOINTMENT.**

- Seek prompt evaluation for immediate medical attention by your primary care physician or Emergency Room if YES to question #1

Print Name: _____

Sign and Date: _____