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Patient Screening Form

Patient Name: ________________________________

It is important that you disclose to our office any indication of you or your child having been exposed to COVID-19, or if you or your child has had symptoms associated with the virus. This information is critical to protect the safety of not only your child, but our team and other patients as well.

Question	Response
Do you or your child have a fever or above normal temperature?	☐ Yes ☐ No
Have you or your child experienced shortness of breath or other difficulties breathing?	☐ Yes ☐ No
Do you or your child have a cough?	☐ Yes ☐ No
Any other flu-like symptoms, such as runny nose, sore throat or fatigue?	☐ Yes ☐ No
Have you or your child recently experienced loss of taste or smell?	☐ Yes ☐ No
Have you or your child been in contact with any confirmed COVID-19 patients?	☐ Yes ☐ No
Have you or your child tested positive for COVID-19 or awaiting test results?	☐ Yes ☐ No
Have you or your child traveled in the past 14 days to any regions affected by COVID-19?	☐ Yes ☐ No

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Parent Signature: ___________________________ **Date:** _______________