Screening Questionnaire

Date: ________________

Patient Name: ______________________________

Patient Temp:

Guardian Temp:

1. Have you, the patient or anyone in your home been in contact with a person with known or suspected COVID-19?

Yes No

2. Have you or anyone in the household been in large crowds in the last two weeks?

Yes No

3. Have you, the patient or anyone in the house been sick with a fever and/or cough in the past 1 week?

Yes No

Please note that we will be checking the temperature of everyone coming into the office. Any adult with a temperature greater than 99.5° will not permitted into the office.

Parent/Guardian Signature ___________________________

Parent/Guardian Name Printed ____