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COVID-19 Patient Screening Form

Patient Name: ______________________________

This patient disclosure form seeks information about you and your child that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

Please disclose to us any condition that compromises your child's immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us. It is also important that you disclose to this practice any indication of having been exposed to COVID-19, or whether you and/or your child have experienced any signs or symptoms associated with the COVID-19 virus.

Do you and/or your child have a fever or above normal temperature? Yes □ No □

Have you and/or your child experienced shortness of breath or had trouble breathing?
Yes □ No □

Do you and/or your child have a dry cough? Yes □ No □

Do you and/or your child have chills, muscle pain or headaches? Yes □ No □

Have you and/or your child recently lost or had a reduction in your sense of smell? Yes □ No □

Do you and/or your child have a sore throat? Yes □ No □

Have you and/or your child been in contact with someone who has tested positive for COVID-19? Yes □ No □

Have you and/or your child tested positive for COVID-19? Yes □ No □

Have you and/or your child been tested for COVID-19 and are awaiting results? Yes □ No □

Have you and/or your child traveled outside the United States by air or cruise ship in the past 14 days? Yes □ No □

Have you and/or your child traveled within the United States by air, bus or train within the past 14 days? Yes □ No □

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.
By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Parent/ guardian signature ______________________________Date: ______________