COVID-19 SCREENING

Patient/Client Name: _____ Date: _____

1. Are you currently experiencing any of the following symptoms? YES NO

- A new fever (100.4°F or higher)
- A new cough that you cannot attribute to another health condition
- New shortness of breath or difficulty breathing that you cannot attribute to another health condition
- A new sore throat that you cannot attribute to another health condition
- A new loss of taste or smell
- Any other known symptoms of COVID-19

2. Have you had a positive test for COVID-19 within the past 10 days or are you worried that you may be sick with COVID-19? YES NO

3. Are you fully vaccinated or have you recovered from a documented COVID-19 infection in the last 3 months? YES NO

If you answered "YES" to Question 3 and "NO" to Questions 1 and 2, please skip to the certification step below.

4. Have you been in close physical contact in the last 14 days with anyone who is known to have laboratory-confirmed COVID-19 or anyone who has any symptoms consistent with COVID-19? YES NO

I certify that my responses are true and correct. Initials: _____