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In order to assure the utmost safety of our patients and team members, please answer the following questions:

1) Have you tested COVID positive in the past? Yes No

If "no", skip to question 2.

1a) If yes, what date did you receive your results? ______________________________

2) In the last 3 days, have you experienced:

Fever ≥ 100.4	Yes	No	Shortness of breath	Yes	No
Cough	Yes	No	Difficulty breathing	Yes	No
Chills	Yes	No	Sore throat	Yes	No
Muscle pain	Yes	No	New loss of taste or smell	Yes	No
Nausea or diarrhea	Yes	No			

If "no", skip to question 3.

2a) If "yes" to 2 or more of the above symptoms, what was the first day you experienced symptoms (symptom onset date)? __________

3) Have you had exposure to a COVID-19 positive person within the last 14 days? Yes No

3a) If "yes", what was the date of your exposure? __________

______________________________ _______________ __________________________
Signature DOB Print Name

____________________ ___________________
Date Time

___________________________ _________________________ ____________________________
Guardian Signature Relationship to Patient Print Name