Patient Pre-Screening Form

Patient Name:_____ DOB:_____

Date:_____

Name of parent: _____

Does the patient or anyone in the family have…

____Fever greater than 100.4 degrees

____Shortness of breath or other breathing difficulties

____Have cough, sore throat, runny nose

____Any flu-like symptoms, such as gastrointestinal upset, headache, fatigue

____Recent loss of taste or smell

____Traveled in the past 14 days to NY, NJ or internationally

____Been in contact with any confirmed COVID-19 positive patients

____None of the above

____ *(Initial)* I will notify the office if my child develops any of the above symptoms within 14 days post-office visit.

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for internal use only:

Screening day of appt:

Date:_____ Symptoms:_____ Temp:_____