Covid-19 Screening form

Per CDC recommendation, the purpose of this is to ensure proper infection control procedures are taken for any patients who may have or potentially have been in recent contact with the *2019-nCOV* (Coronavirus) to prevent infection from spreading during healthcare delivery. Note that the signs and symptoms of *Covid-19* overlap with those associated with other viral respiratory tract infections. Given the time of year, common respiratory illnesses, including influenza are also considered.

1. Are you experiencing any symptoms of respiratory illness, fever, dry cough, difficulty breathing or shortness of breath?

   ☐ Yes ☐ No

2. If yes, approximately what date did the symptoms start? (/ /)

3. In the past 14 days, have you traveled internationally?

   ☐ Yes ☐ No

4. If yes, where to? _____

5. In the past 14 days, have you had close contact with a person you known to have *Coronavirus?*

   ☐ Yes ☐ No

6. Have you been vaccinated?

   ☐ Yes ☐ No

*Mask will be required for those who have not been vaccinated per CDC guidelines.

_____

(Print Name)

_____

(Signature)

_____

(Date)