COVID19 Questionnaire

Please print and complete this form and bring it with you.

Name ____

Date ____

COVID19 Information:

1. Have you had a a fever in the last 24 hours of 100°F or above? Yes ❑ No ❑
2. Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath? Yes ❑ No ❑
3. Do you now, or have you recently had, any chills, muscle aches, new loss of taste or smell, or new rashes or lesions? Yes ❑ No ❑
4. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID19 or has coronavirus-type symptoms? Yes ❑ No ❑

Client Signature ______________________________________ Date _______________

Parent or Guardian Signature (in case of minor _____________ Date _______________