COVID-19 PATIENT SCREENING

Patient Name: _____ Date of Birth: _____

Temperature:

Patient's Temperature: _____

Date temperature was taken: _____Time temperature was taken: _____

Have you had any of the following symptoms?

Chills	Yes	No
Headaches	Yes	No
Loss of smell	Yes	No
Fever	Yes	No
Sore Throat	Yes	No
Cough	Yes	No
New shortness of breath	Yes	No

Have you been exposed to anyone with confirmed COVID-19? Yes No

Please list your travel history for last 1 month:

_____

If you have answered yes to any of the above, please exit building and self-quarantine.

I _____ understand that the

is doing everything possible to eliminate the risk of spreading SARS-COVID-2 virus. However, I have been informed that I assume responsibility for hand washing, wearing my own protective wear, and taking my own safeguards.

By visiting_____ I release them of any exposure liability that may affect my health.

Name:_____ Date:_____

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