



COVID-19 Patient Screening Form

Child's Name	
Person Completing Form	

Screening Questions <i>Do you, your child, or anyone in your household or any household your child resides in have any of the following symptoms?</i>	Confirmation Date: / / Screener:	At Appointment:	Notes
Fever greater than 100.4°	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Shortness of breath or trouble breathing	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Dry cough	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Reduction or loss of taste or smell	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Sore throat	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Chills	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Unexplained muscle pain	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Headache	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Diarrhea	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Any of the above symptoms in past 14 days	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Been in contact with anyone who has had these symptoms or tested positive for Covid-19 in the last 14 days	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Traveled more than 100 miles in the last 14 days	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Have you, or your child, been tested for COVID-19 in the last 14 days? If "no" proceed to next question. If yes , what is the ruling of the testing? If negative , proceed to next question. If still waiting on results , schedule appointment after results are known.	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NEGATIVE <input type="checkbox"/> UNSURE <input type="checkbox"/> POSITIVE	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NEGATIVE <input type="checkbox"/> UNSURE <input type="checkbox"/> POSITIVE	

Patient signature required at appointment:

I agree to notify the dental practice if within 14 days I, or my child, become ill with COVID-19 symptoms or test positive for COVID-19. I understand the dental practice has a legal and ethical obligation to inform me if a staff person I had contact with tested positive for COVID-19 within 14 days.

Signature _____

Printed Name: _____

Date: _____

For office use only:	Screener:	Date:	Parent Temp:	Child Temp:
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