[Insert County Name] Department of Social Services

COVID 19 Health Screening Tool

_____

Parent Name

On the day of, but before the visit:

1. Have you had any signs or symptoms of a fever in the past 24 hours such as chills, sweats, felt "feverish" or had a temperature that is elevated for you or is ≥ 100.0°F?

   ☐ Yes ☐ No

2. Do you have any of the following symptoms?

   ☐ Cough ☐ Shortness of Breath or difficulty breathing ☐ Fever

   ☐ Chills ☐ Repeated Shaking with Chills ☐ Muscle Pain

   ☐ Headache ☐Sore Throat ☐ A new loss of taste or smell

3. Have you been in contact with someone with a confirmed diagnosis of COVID19 within the last 14 days?

   ☐ Yes ☐ No

4. Do you have a face covering or mask?

   ☐ Yes ☐ No

At the visit:

5. Did you wash your hands after entering the building?

   ☐ Yes ☐ No

_____ _____

Parent Signature Date