[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