[Insert County Name] Department of Social Services
COVID 19 Health Screening Tool

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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 $\geq 100.0^\circ$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