COVID-19 Screening

Respiratory Illness Signs & Symptoms

For the safety of our patients and team members please complete the following screening

Patient Name________________________________ DOB____/____/____ Temp__________

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Do you / or a family member:

1)	Have a fever (100.4F or greater)?	YES	NO
2)	Have a cough (Not related to allergies)?	YES	NO
3)	Have shortness of breath?	YES	NO

Have you / or a family member:

4)	Been in close contact with any person suspected to have COVID-19?	YES	NO
5)	Been in close contact with any person with a confirmed COVID-19?	YES	NO
6)	Traveled outside of Colorado within the past 14 days?	YES	NO
7)	Traveled outside of the United States within the past 30 days?	YES	NO
8)	Traveled to the mountains in Colorado since March 7th, 2020?	YES	NO

Thank you for completing this form. We appreciate your cooperation and patience during this time.

Parent Signature____ Date________________________