COVID-19 SCREENING QUESTIONNAIRE

Patient's name: Date of exam:
Current body temp child: Parent temp:

Questionnaire is applied to patient and anyone in the immediate household- in the past 14 days

	YES	NO
Does child have or has had any of the following symptoms		
Fever (greater than 38 deg C or 100.4 deg F)	__	__
Severe Headache	__	__
Muscle pain		
Weakness	__	__
Diarrhea/Vomiting/Abdominal pain	__	__
Respiratory illness: coughing, difficulty with breathing	__	__
Rash/Skin irritation	__	__
Unexplained bleeding or bruising	__	__
Does child experience these symptoms every year (i.e., seasonal allergies)?	__	__
Has child traveled anywhere outside of Santa Barbara county. If yes, where?	__	__
Has child come into contact with a patient with confirmed COVID-19 infection?	__	__
Has child come into contact with people who have traveled to locations with documented high infection rate?	__	__
Are there at least 2 people with documented experience of fever or respiratory problems having close contact with child?	__	__
Has child or immediate related person recently participated in any gathering, meetings, or has close contact with others in large gatherings, and now showing symptoms	__	__

Is child's dental appointment an emergency or is it an elective procedure that can wait?

Only 1 parent can accompany child into the treatment area.
Does the parent have a mask to wear for him/herself __ __

Signature of parent or guardian: ______________________________