**The Whole Child Associates: Screening for COVID-19**

**Client Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_

**1. Have you or any members in your household, traveled outside of US in the last 3 wks.**

Yes\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

**If so, was it in a place of high infection rate? Yes \_\_\_ No \_\_ Where? \_\_\_\_\_\_\_\_\_\_**

\*Affected areas are geographic regions where sustained community transmission has been identified and are updated by the CDC. Current affected areas can be found at: [www.cdc.gov/coronavirus/2019-ncov;travelers](http://www.cdc.gov/coronavirus/2019-ncov;travelers).

**2. Have you been on a cruise or traveled by air in last 21 days**: Yes\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_

**3. Have you been in close contact\*\* with any person diagnosed (laboratory confirmed) with the COVID-19:** Yes \_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_

\*\*Close contact is defined as: Being within approximately 6 feet (2 meters) of a COVID-19 case for greater than 15 minutes; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case, or having direct contact with infectious secretions of a COVID-19 case (e.g.,being coughed on).

**4. Are you experiencing severe acute lower respiratory illness (cough, shortness of breath) and fever? Yes No**

**5. Do you have a Fever? Yes No**

**6. Have you been tested for COVID-19?**

**When was the test? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What were the results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please check if you are experiencing any of the following as a New Pattern since the beginning of the pandemic:**

**\_\_Fever \_\_Diarrhea, digestive upset \_\_Nasal, sinus congestion**

**\_\_Chills \_\_Loss of sense of taste or smell \_\_Fatigue**

**\_\_Cough \_\_Shortness of breath \_\_Sudden onset of muscle soreness**

**\_\_Sore throat \_\_Rash or skin lesion (especially in feet)**

I attest the information provided is accurate and honest. I am aware of the risks of Covid-19 and that the circumstances surrounding the virus are continuously evolving. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive treatment at this time with The Whole Child Associates.

I understand that my name and contact information might be shared with the state health department in the event that a client or practitioner at this facility tests positive for COVID 19. My contact details will only be shared in the event they are relevant based on suspected exposure date and only for appropriate follow-up by the health department.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_