Chestnut Ridge Pediatric Dental

COVID-19 SCREENING FORM

- Please answer for each person who is coming to appointment, whether child or parent.
- If the answer for one person is YES and another person is NO, please indicate which answer is for which person.

Do you have fever, or have you felt feverish in the last 14 days?	YES	NO
Are you having any difficulty breathing?	YES	NO
Do you have a cough?	YES	NO
Do you have other flu-like symptoms such as stomachache, headache, or fatigue?	YES	NO
Have you recently lost your sense of taste or smell?	YES	NO
Have you been in contact with any confirmed COVID-19 positive patients?	YES	NO
Do you have any autoimmune disorders or lung disease?	YES	NO
If lung disease, is it well-controlled asthma?	YES	NO

Name of person filling out form (please print)

Signature & Date

Name(s) of children

TO BE FILLED OUT BY STAFF: Temperature WNL >100.4

If filled out earlier, is information still correct? YES NO