COVID-19 Screening Form

To be completed by patient or patient's legal guardian if under 18 years:

First Name: _____ Middle Initial: _____ Last: _____ Date of Birth: ____/____/____

This guidance is intended for screening patients prior to receiving immunization services. It is not intended for people with confirmed or suspected COVID-19, including persons under investigation. Individuals with confirmed or suspected COVID-19 should not receive immunization services and should follow current CDC guidance for quarantine and self-isolation.

Please answer the following questions:

Do you have any of the following?

- Fever greater than 100.4*F [38.0*C] within the past 72 hours? Yes / No
- Shortness of breath Yes / No
- Cough Yes / No
- Chills Yes / No
- Repeated shaking with chills Yes / No
- Muscle pain Yes / No
- Headache Yes / No
- Sore Throat Yes / No
- New loss of taste or smell Yes / No

Are you ill or caring for someone who is ill? Yes / No

Have you had contact with someone diagnosed with COVID-19 in the past two weeks? Yes / No

Have you lived in or visited a place with active COVID-19 cases in the past two weeks? Yes / No

ATTESTATION: I attest that the answers provided above are accurate to the best of my knowledge.

Patient Signature: _____ **Date:** _____
Person to receive vaccination or person authorized (if physically unable or less than 18 years of age)

For Pharmacy Staff: Administer this questionnaire prior to assessing patient's temperature and delivering immunization services. A copy of this form should be stored with the immunization consent form and retained with prescription records.