****

**Name**

**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SCREEENING QUESTIONS**

1. Do you (your child) have any of the following symptoms: have a fever, new cough, worsening chronic cough, shortness of breath or difficulty breathing?

**YES\_\_\_\_ YES\_\_\_\_**

**NO\_\_\_\_ NO\_\_\_\_**

1. Have you (your child) had close contact with anyone who has a confirmed case of COVID-19 or has an acute respiratory illness?

**YES\_\_\_\_ YES\_\_\_\_**

**NO\_\_\_\_ NO\_\_\_\_**

1. Do you (your child) have TWO (2) or more of the following symptoms: Sore throat, runny nose/sneezing, nasal congestion, hoarse voice, difficulty swallowing, decrease or loss of sense of smell, chills, headaches, unexplained fatigue, diarrhea, abdominal pain or nausea/vomiting?

**YES\_\_\_\_ YES\_\_\_\_ Which symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NO\_\_\_\_ NO\_\_\_\_**

1. **If the person is over 65 years of age**. Are you experiencing any of the following: delirium, falls, acute functional decline, or worsening of chronic conditions?

**YES\_\_\_\_\_ YES\_\_\_\_\_**

**NO\_\_\_\_\_ NO\_\_\_\_**

**Completed by (1):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Completed by (2):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notes:**