DAILY COVID-19 QUESTIONNAIRE

Date_____

Child's name: _____ **Completed by**_____

Temperature is required.

Screening Time:_____ Temperature:_____

In the past 24 hours, has the child or other household member experienced:

Fever/chills:	• YES	• NO
Fatigue:	• YES	• NO
Cough:	• YES	• NO
Body aches and pains:	• YES	• NO
Sore throat:	• YES	• NO
Runny or stuffy nose:	• YES	• NO
Shortness of breath or difficulty breathing:	• YES	• NO
Loss of smell and/or taste:	• YES	• NO
Headache:	• YES	• NO
Nausea/vomiting/diarrhea:	• YES	• NO

Has the child or other household member recently been in close contact with anyone who has exhibited any symptoms of COVID-19?

• YES • NO

Has the child or other household member recently been in contact with anyone who has tested positive for COVID-19?

• YES • NO

In the past 14 days has the child or other household member been told by a local government or public health authority to isolate for any COVID-19 related reason? • YES • NO

Has the child or other household member recently traveled outside of the Country or within the United States in the last 14 days?

• YES • NO

Although exposure to COVID-19 while at OTM Speech is unlikely, do you accept the risk of treatment today? • YES • NO

I understand that this information is being taken for the safety of OTM staff and patients due to the COVID-19 pandemic and will be provided upon request, as required by law, to the Jefferson County Department of Health.

I attest that the foregoing information is true and correct.

Name _____ Relationship to Child_____

Signature _____ Date _____