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COVID 19 Screening Form

This form must be completed by EVERYONE 18 years and older and completed by a **parent or legal guardian** for those under 18 years of age.

_____(initial) I have NOT had any symptoms of acute respiratory infection (e.g., fever, cough, difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell) during the last two weeks.

_____(initial) To my knowledge I have NOT had contact with any individual with acute respiratory symptoms infection (e.g., fever, cough, difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell) or been in a high risk environment during the last two weeks.

_____(initial) I have NOT traveled outside of the State of Alaska in the last two weeks.

_____(initial) To the best of my knowledge all the statements above apply to Both myself and the following minors who accompanied me.

_____
Name of Minor

_____
Name of Minor

If ANY of these above statements apply to you or the minors you accompanied, then please obtain clearance from your primary care provider before your appointment.

If you are unable to make today's scheduled appointment for this reason, then please contact Jessica at 907-764-7466 to discuss telehealth option.

Thank you for your understanding and cooperation as we work to minimize the risk of COVID-19 for our patients, staff, and community.

_____

Print Name Date Client Name Relationship to Client

_____
Signature