Santa Rosa Pediatric Dentistry

COVID-19 Patient Screening Form

Child's Name	
Person Completing Form	

Screening Questions *Do you, your child, or anyone in your household or any household your child resides in have any of the following symptoms?*	**Confirmation Date:** / / **Screener:**	**At Appointment:**	**Notes**
Fever greater than 100.4°	☐ YES ☐ NO	☐ YES ☐ NO	
Shortness of breath or trouble breathing	☐ YES ☐ NO	☐ YES ☐ NO	
Dry cough	☐ YES ☐ NO	☐ YES ☐ NO	
Reduction or loss of taste or smell	☐ YES ☐ NO	☐ YES ☐ NO	
Sore throat	☐ YES ☐ NO	☐ YES ☐ NO	
Chills	☐ YES ☐ NO	☐ YES ☐ NO	
Unexplained muscle pain	☐ YES ☐ NO	☐ YES ☐ NO	
Headache	☐ YES ☐ NO	☐ YES ☐ NO	
Diarrhea	☐ YES ☐ NO	☐ YES ☐ NO	
Any of the above symptoms in past 14 days	☐ YES ☐ NO	☐ YES ☐ NO	
Been in contact with anyone who has had these symptoms or tested positive for Covid-19 in the last 14 days	☐ YES ☐ NO	☐ YES ☐ NO	
Traveled more than 100 miles in the last 14 days	☐ YES ☐ NO	☐ YES ☐ NO	
Have you, or your child, been tested for COVID-19 in the last 14 days? If "no" proceed to next question. **If yes**, what is the ruling of the testing? **If negative**, proceed to next question. **If still waiting on results**, schedule appointment after results are known.	☐ YES ☐ NO ☐ NEGATIVE ☐ UNSURE ☐ POSITIVE	☐ YES ☐ NO ☐ NEGATIVE ☐ UNSURE ☐ POSITIVE	

Patient signature required at appointment:

I agree to notify the dental practice if within 14 days I, or my child, become ill with COVID-19 symptoms or test positive for COVID-19. I understand the dental practice has a legal and ethical obligation to inform me if a staff person I had contact with tested positive for COVID-19 within 14 days.

Signature ______________________________

Printed Name: ______________________________

Date: ______________________________

For office use only:	Screener:	Date:	Parent Temp:	Child Temp: