Daily Home Screening for Students

Parents: *Please complete and return this questionnaire to us before your child's appointment today.*

PATIENT NAME: _____ DOB: _____

ACCOMPANIED BY (*List All*): _____

_____

SECTION 1: Symptoms

If you or anyone you are with at Touchpoint Pediatrics has any of the following symptoms, that may indicate a contagious illness. Please indicate if anyone with you today has any symptoms on the following list:

YES	NO	
☐	☐	Temperature 100.4 degrees Fahrenheit or higher when taken by mouth
☐	☐	Sore throat
☐	☐	New uncontrolled cough or difficulty breathing (for students with chronic allergic/asthmatic cough, a change in their cough from baseline)
☐	☐	Diarrhea, vomiting, or abdominal pain
☐	☐	New onset of severe headache, especially with a fever
☐	☐	Extreme fatigue or body aches

DATE OF SYMPTOM ONSET: _____

SECTION 2: Close Contact/Potential Exposure/Exposure/Vaccination

YES	NO	
☐	☐	Had close contact (within 6 feet of an infected person for at least 15 minutes) with a person with confirmed COVID-19
☐	☐	Traveled to or lived in an area where the local or state health department is reporting large numbers of COVID-19 cases within the past 14-days.
☐	☐	Have you ever tested positive for COVID-19? If so, when & at what facility:
☐	☐	Have you provided the COVID-19 results documentation to Touchpoint Pediatrics?
☐	☐	Has the patient been vaccinated for COVID-19?
☐	☐	Have you provided the COVID-19 vaccination documentation to Touchpoint Pediatrics?

Parent Signature: _____ **Date of Visit:** _____

*** FOR TELEMEDICINES:**

Please complete before your appointment and upload to our website: touchpointpediatrics.com under the contact tab in the top right corner, this is not through the portal.

TOUCHPOINT PEDIATRICS, P.A.
touchpointpediatrics.com
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cdc.gov/coronavirus