

COVID-19 Screening Form



To be completed by patient or patient's legal guardian if under 18 years:

First Name: _____ Middle Initial: _____ Last: _____ Date of Birth: ____/____/____

This guidance is intended for screening patients prior to receiving immunization services. It is not intended for people with confirmed or suspected COVID-19, including persons under investigation. Individuals with confirmed or suspected COVID-19 should not receive immunization services and should follow current CDC guidance for quarantine and self-isolation.

Please answer the following questions:

Do you have any of the following?

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| ▪ Fever greater than 100.4°F [38.0°C] within the past 72 hours? | Yes / No |
| ▪ Shortness of breath | Yes / No |
| ▪ Cough | Yes / No |
| ▪ Chills | Yes / No |
| ▪ Repeated shaking with chills | Yes / No |
| ▪ Muscle pain | Yes / No |
| ▪ Headache | Yes / No |
| ▪ Sore Throat | Yes / No |
| ▪ New loss of taste or smell | Yes / No |

Are you ill or caring for someone who is ill?	Yes / No
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Have you had contact with someone diagnosed with COVID-19 in the past two weeks?	Yes / No
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Have you lived in or visited a place with active COVID-19 cases in the past two weeks?	Yes / No
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ATTESTATION: I attest that the answers provided above are accurate to the best of my knowledge.

Patient Signature: _____ **Date:** _____

Person to receive vaccination or person authorized (if physically unable or less than 18 years of age)

For Pharmacy Staff: Administer this questionnaire prior to assessing patient's temperature and delivering immunization services. A copy of this form should be stored with the immunization consent form and retained with prescription records.