connectcare
MEDICAL CLINIC + PHARMACY

COVID-19 SCREENING FORM

During the COVID pandemic we ask that all patients & visitors complete this form.

Please circle YES or NO to all questions below, to confirm you agree to our policies.

PATIENT/VISITOR	First Name:	Last Name:

1. Do you have the following symptoms?

a) Fever > 38 Degrees C ..... YES or NO
b) Chills ..... YES or NO
c) Cough ..... YES or NO
d) Sore Throat ..... YES or NO
e) Stuffy or Runny Nose ..... YES or NO
f) Pneumonia ..... YES or NO
g) Shortness of breath or Difficulty Breathing ..... YES or NO
h) Feeling unwell, fatigue or severe exhaustion? ..... YES or NO
i) Headache? Muscle or Joint ache? (New onset, not chronic) ..... YES or NO
j) Nausea, vomiting, diarrhea, or Unexplained loss of appetite? ..... YES or NO
k) Loss of sense of smell or taste? ..... YES or NO
l) Eye irritation or pink eye? ..... YES or NO

2. Have you come into contact with anyone that has *any* of the above symptoms in the last 14 days? ..... YES or NO

3. Have you travelled or been in contact *with* anyone who has travelled in the past 14 days? ..... YES or NO

*If you indicate **YES** to any of the above questions, please notify us immediately, call 811 for next steps.*

☐ **I HEREBY CERTIFY & AGREE THAT ALL MY RESPONSES ABOVE ARE ACCURATE TO THE BEST OF MY KNOWLEDGE.**

☐ **I UNDERSTAND that ConnectCare has the right to refuse service to me, should I enter the premise knowingly travelled or been in contact with someone who has travelled or if I present with any of the symptoms indicated above.**

Patient Signature: _____ **Date:** _____

Caregiver/ Parent Signature: _____ **Date:** _____

INTERNAL USE	**Patient /Visitor Temperature Recorded:**	**Witness/Staff Name:**	**Initials (Staff):**
		Date:	**Time:**