DEVELOPMENTAL +REHABILITATIVE SERVICES II

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COVID-19 Screening Questionnaire

1. Have you or anyone in your household traveled internationally within the last 30 days?
   a. Yes _____ No _____
   b. If yes, where? _____
2. Have you had close contact with a suspected or laboratory-confirmed COVID-19 patient in the past 2 weeks?
   a. Yes _____ No _____
3. Has anyone in your household had close contact with a suspected or laboratory-confirmed COVID-19 patient in the past 2 weeks?
   a. Yes _____ No _____
4. In the last **72 HOURS** have you had:

a. Temperature of 99.5 degrees or higher	YES _____	NO _____
b. Cough	YES _____	NO _____
c. Shortness of breath	YES _____	NO _____
d. Sore throat	YES _____	NO _____
e. Headache	YES _____	NO _____
f. Repeated shaking chills	YES _____	NO _____
g. Muscle pain	YES _____	NO _____
h. New onset loss of taste or smell	YES _____	NO _____

5. The following patients will be cancelled/rescheduled if they have:
   - Flu-like symptoms
   - Temperature of 99.5 degrees or greater
   - Contact with a suspected or confirmed COVID-19 patient
   - Quarantine order issued
   - Visited a Level 2 or 3 travel Health Notice country in the past 2 weeks
   - Returned from a cruise in the past 2 weeks

Print Name: _____

Signature: _____ Date: _____

Employee: _____ Date: _____