COVID-19 Pre-Session Health Screening

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please answer yes or no to the following questions and give additional information as needed.

Have you experienced any cold or flu-like symptoms in the last 14 days?

Has a health professional asked you to self-isolate in the last 14 days?

Have you experienced any loss of taste or smell?

Have you experienced any severe or deep muscle aching?

Have you noticed any changes in your skin such as reddening or looking rash like?

Have you been in close contact with someone experiencing cold or flu-like symptoms or have you cared for someone testing positive for COVID-19 in the last 14 days?

Have you been tested for COVID-19 in the last 14 days and if yes, what was the result?

Have you recently traveled or returned from a trip?

I have answered the above truthfully and understand that I can be refused treatment based on the above answers.

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_