Coastside Pediatric Therapy Center

Covid-19 Questionnaire from Coastside Pediatric Therapy Center

Please answer the following questions in regard to you and your child before their visit each week to the clinic:

Child's name: _____

Child's Temperature taken in clinic: _____

Date of clinic visit: _____

Caregiver's name: _____

Do you have a fever or felt hot or feverish in the past 14 days? Yes / No

Do you have shortness of breath or other difficulties breathing? Yes / No

Do you have a cough? Yes / No

Do you have any other flu-like symptoms such as gastrointestinal upset, headache or fatigue? Yes / No

Have you experienced recent loss of taste or smell? Yes / No

Have you had a close contact with a person infected with Covid -19? Yes / No

Have you travelled in the last 14 days? Yes / No

Is there anything else our team should know before treating you? Yes / No

Please date: _____

Please sign: _____