Canyon Kids
Occupational Therapy

Health Screening Questions During COVID-19

Child's Name: _____

Reporter: Parent Nanny Other:

Date: _____

Child's Temperature: _____

Therapist Initials: _____

Please note any response indicating possible illness or exposure to COVID-19.

1. Does your child or has anyone in your family experienced any of the following in the past 7-14 days?
    - Fever, chills or felt hot?
    - Cough?
    - shortness of breath/difficulty breathing?
    - Fatigue?
    - muscle or body aches?
    - Headache?
    - new loss of taste of smell?
    - sore throat?
    - congestion or runny nose?
    - nausea or vomiting?
    - Diarrhea?

2. Has your child or anyone living in your home come in contact with someone with a confirmed COVID-19 diagnosis in the past two weeks?

3. Has your child or anyone living in your home traveled domestically or internationally to a region heavily affected by COVID-19 in the past two weeks?

4. Has your child or anyone living in your home attended any large gatherings (>20 people) or come in contact with many unacquainted people in the past two weeks.

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