PEDIATRIC OPHTHALMOLOGY
& ADULT STRABISMUS
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COVID - 19 SCREENER

Please answer the following questions as they apply to **both you and the patient:**

1. Have you had any **signs or symptoms of a fever** in the past 24 hours such as chills, sweats, felt "feverish" or had a temperature that is elevated for you/100.0F or greater?	❑ No ❑ Yes
2. Do you have any of the following symptoms? ○ Cough ○ Shortness of Breath or Chest Tightness ○ Sore Throat ○ Myalgia (Body Aches) ○ Loss of Taste and/or Smell ○ Diarrhea ○ Nausea ○ Vomiting ○ Fever/Chills/Sweats	❑ No ❑ Yes, ❑ If so - what symptoms?
3. Have you been in contact within the last 20 days with someone with a confirmed diagnosis of COVID-19?	❑ No ❑ Yes
4. Have you traveled outside of the state in the last 20 days?	❑ No ❑ Yes - Where?

Patient Name: _____ Patient/Guardian Signature: _____

Accompanied by: _____ Relationship to patient: _____

Signature: _____ Date: _____