Pelosi Medical Center

COVID-19 SCREENING

Patient Name: _____

Birthdate: ____/_____/____ MR #: _____

PATIENT NAME: _____ **BIRTHDATE:** _____/_____/_____

Temperature: _____

Have you had any of the following symptoms?

Cough……	Y	N
Shortness of Breath……	Y	N
Fever……	Y	N
Repeated shaking with chills……	Y	N
Headache……	Y	N
New loss of taste or smell……	Y	N
Muscle pain……	Y	N
Sore throat……	Y	N
Vomiting……	Y	N
Diarrhea……	Y	N

If YES to any, restrict patient from entering the building.

Have you been exposed to anyone with confirmed COVID-19? Y N

If YES, please exit building and self-quarantine for 14 days.

I, _____, understand that Pelosi Medical Center is doing everything possible to eliminate the risk of spreading COVID-19 virus. However, I have been informed that I assume responsibility for hand washing, wearing my own protective wear, and taking my own safeguards. By visiting Pelosi Medical Center, I release them of any exposure liability that may affect my health.

_____ _____

Patient Signature Date