Park Cities Child and Family Counseling

COVID WEEKLY SCREENING FORM

Please initial each of the following:

1. _________ In the past 14 days, have you, your child, or someone who shares your household, been diagnosed (either as a presumptive or laboratory-confirmed diagnosis) with COVID-19?
2. _________ Have you, your child, or anyone in your household been advised by a doctor, healthcare provider, or any public health authority to stay home or otherwise avoid contact with others?
3. _________ Have you, your child, or anyone in your household been free of fever, coughing, shortness of breath, or other symptoms associated with COVID-19 for at least 24 hours?
4. _________ In the past 14 days, has anyone in the household traveled to any of the following locations within the US: California; Connecticut; New York; New Jersey; Washington; Atlanta, Georgia; Chicago, Illinois; Detroit, Michigan, and Miami, Florida? Be advised the Governor of Texas has issued a 14-day quarantine for all travelers to Texas from these US locations.
5. ________ In the past 14 days, has anyone in the household traveled to any countries with Level 3 Travel Health Notice as designated by the Centers for Disease Control? For information regarding Travel Health Notices, please see https://www.cdc.gov/ coronavirus/2019-ncov/ travelers/after-travel- precautions.html.
6. _______ If your answer to any of these questions is yes, we respectfully ask that you do not visit our offices as scheduled.

Once this form is completed, please print your or your child's name below, sign, and date it. Then email to your provider at least 2 hours prior to the start of session time. Failure to do this could result in the cancellation or rescheduling of your session. Thank you for your understanding.

____

Client Printed Name

____

Client Signature (Parent/Guardian, if minor)

____

Date