childneuropsychologypc
2223 NE 47th Avenue
Portland, OR 97213
503 335-2223 Fax 503 282-1332

PRE-APPOINTMENT HEALTH SURVEY

I _________________________, parent/caregiver of ________________________________
Parent name   Child Name

affirm that my child and no one in our immediate household has exhibited any of the following symptoms in the last 24 hours:

RESPIRATORY SYMPTOMS
Sore throat
Dry cough
Shortness of breath or difficulty breathing
Runny nose or nasal congestion

FEVER
A measured temperature of 100.0^{0} F or higher
A sense of having a fever
Use of fever reducing medication
Body chills

ADDITIONAL SYMPTOMS
Fatigue or feeling extra tired
Muscle or body aches
Headache
Abdominal pain
New loss of taste or smell
Nausea or vomiting
Diarrhea
Neck Pain
Rash
Bloodshot eyes

EXPOSURE
No one in our household has been exposed to someone showing signs of COVID-19 infection or to someone with a known case of COVID-19. WITHIN THE PAST 14 DAYS.

____   _______________________
Parent/ guardian Signature   Date