HONOR HF FRANKLIN
MYOFUNCTIONAL & SPEECH CLINIC

Please complete and sign this form BEFORE you or your child visit our clinic.

Thank you for putting your trust in our office and we are so happy to see you. This form allows us to screen for communicable diseases including COVID-19 in an effort to keep all of our patients and team safe. For each appointment, we will need you to answer the questions below.

Any "YES" answer to a question means that we will need to reschedule your appointment at a later date.

Are you experiencing:

Fever/Chills:	YES	NO
Fatigue:	YES	NO
Cough:	YES	NO
Body aches and pains:	YES	NO
Sore throat:	YES	NO
Runny or stuffy nose:	YES	NO
Shortness of breath or difficulty breathing:	YES	NO
Loss of smell and/or taste:	YES	NO
Headache:	YES	NO
Nausea/vomiting/diarrhea:	YES	NO

Have you or your child been in contact with any confirmed COVID-19 positive person?

YES NO

In the past 14 days, have you or your child been told by a local government or public health authority to isolate for any COVID-19 related reason?

YES NO

Have you or your child traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)

YES NO

I understand that this information is being taken for the safety of our patients and team due to the COVID-19 pandemic.

I attest the foregoing information is true and correct.

NAME: _____

SIGNATURE: _____

DATE:_____