ACME Fresh Market PHARMACY
Your Hometown Pharmacy

COVID-19 Screening Form

To be completed by patient or patient's legal guardian if under 18 years:

First Name: _____ Middle Initial: _____ Last: _____ Date of Birth: ____/____/____

This guidance is intended for screening patients prior to receiving immunization services. It is not intended for people with confirmed or suspected COVID-19, including persons under investigation. Individuals with confirmed or suspected COVID-19 should not receive immunization services and should follow current CDC guidance for quarantine and self-isolation.

Please answer the following questions:

Do you have any of the following?

▪ Fever greater than 100.4*F [38.0*C] within the past 72 hours?	Yes / No
▪ Shortness of breath	Yes / No
▪ Cough	Yes / No
▪ Chills	Yes / No
▪ Repeated shaking with chills	Yes / No
▪ Muscle pain	Yes / No
▪ Headache	Yes / No
▪ Sore Throat	Yes / No
▪ New loss of taste or smell	Yes / No
Are you ill or caring for someone who is ill?	Yes / No
Have you had contact with someone diagnosed with COVID-19 in the past two weeks?	Yes / No
Have you lived in or visited a place where with active COVID-19 cases in the past two weeks?	Yes / No

ATTESTATION: I attest that the answers provided above are accurate to the best of my knowledge.

Patient Signature: _____ **Date:** _____
Person to receive vaccination or person authorized (if physically unable or less than 18 years of age)

For Pharmacy Staff: Administer this questionnaire prior to assessing patient's temperature and delivering immunization services. A copy of this form should be stored with the immunization consent form and retained with prescription records.

>For the protection of our pharmacy staff, please wear a face mask during your immunization visit.
Thanks. Acme Pharmacy