BOYER
CHILDREN'S CLINIC

Health Screening for COVID-19

1 Has anyone in your home received a positive COVID19 diagnosis and has not yet tested negative twice OR received confirmation from a health provider that a period of home isolation is completed?

2 Has anyone in your home been directly exposed to someone who is suspected of having or diagnosed with COVID-19 in the past 14 days?

3 Has anyone in your home recently been ill with any of these symptoms in the last 14 days?

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Nasal congestion or runny nose
- Nausea or vomiting
- Diarrhea

Please let your provider know if the answer is "yes" to ANY of the 3 questions above.