

**Questionnaire will need to be answered both prior to and day of appointment.

WASATCH HOLLOW ANIMAL HOSPITAL HOME VETERINARY CARE <u>COVID-19 SCREENING</u>		
PLEASE READ EACH QUESTION CAREFULLY	CIRCLE THE ANSWER THAT APPLIES TO YOU	
Have you experienced any of the following symptoms in the past 48 hours: <ul style="list-style-type: none"> ● fever or chills ● cough ● shortness of breath or difficulty breathing ● fatigue ● muscle or body aches ● headache ● new loss of taste or smell ● sore throat ● congestion or runny nose ● nausea or vomiting ● diarrhea 	YES	NO
Within the past 14 days, <u>have you been in close physical contact</u> (6 feet or closer for at least 15 minutes) with a person who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19?	YES	NO
Within the past 14 days, <u>has any member of the household we are visiting</u> been in close physical contact (6 feet or closer for at least 15 minutes) with a person who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19?	YES	NO
Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	YES	NO

Are there any members of this household isolating or quarantining because they may have been exposed to a person with COVID-19 or are worried that they may be sick with COVID-19?	YES	NO
Are you or any members of this household currently waiting on the results of a COVID-19 test?	YES	NO

*If you answered yes to any questions, staff access to your household has been denied.
Appointment will need to be rescheduled based on CDC recommendations.*

SIGNATURE _____ DATE _____

By signing my name above, I confirm the information provided in this document is true. I understand that these questions are asked to ensure the safety of the Wasatch Hollow Animal Hospital Staff.