

Please Review Before Beginning Session

Client Name _____ Date _____

1. Self-Check in:

Are you or anyone in the home feeling ill? There is a wide range of symptoms reported for COVID 19. The CDC reports that the above symptoms may appear from 2-14 days after an exposure to the virus. People with these symptoms may have COVID 19:

<input type="checkbox"/>	Fever (greater than 100.4)	<input type="checkbox"/>	Muscle Pain/aches
<input type="checkbox"/>	Cough	<input type="checkbox"/>	Headache
<input type="checkbox"/>	Shortness of Breath/Trouble Breathing	<input type="checkbox"/>	Sore Throat
<input type="checkbox"/>	Chills/shaking with chills	<input type="checkbox"/>	New loss of taste or smell
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Congestion or runny nose
<input type="checkbox"/>	Nausea or vomiting	<input type="checkbox"/>	Diarrhea

This list is updated per the CDC website: <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>

Has anyone in the home experienced any of the above symptoms in the last 14 days? ☐ Yes ☐ No

If YES: Have you or another family member been tested for COVID 19? ☐ Yes Date _____ Results _____ ☐ No

2. Have you or anyone in your home had direct personal contact with someone with symptoms of COVID 19 or are the caregiver to someone who has been diagnosed with COVID 19 in the last 14 days?

☐ Yes ☐ No

If the answer is yes to questions 1 or 2 above, you are asked to notify your Clifford Beers team. All in person visiting will be placed on hold. Please contact your health care provider for the next steps.

3. If you or your family have traveled to a state, or country, that has significant community spread, the state of CT/CDC has issued a quarantine for 14 days. Have you or your child traveled out of the state in the last 14 days?

☐ Yes If yes: Where? _____ Date returned to CT _____ ☐ No

***If yes: Please check the State Website: <https://portal.ct.gov/Coronavirus/Covid-19-Knowledge-Base/Travel-In-or-Out-of-CT>**

If the answer was Yes to any of the questions 1 -3 (and your out-of-state travel is on the list of states requiring quarantine upon return), you and your family may not participate in in-person sessions. Your provider will coordinate with you to return to telehealth sessions until you have been symptom free and quarantined for 14 days, have a negative result from a COVID-19 test, or your health care provider has approved a return to in-person treatment.

Masks must be worn during all in person sessions.

Parent/Guardian

Signature

First Name

Last Name

Date