XPRESS URGENT CARE
WALK IN CLINIC

COVID History form (Pediatric)

A. **Student's Information:**

1 Name: Last: _____ First: _____ Middle: _____

2. Date of Birth: _____/_____/_____

3. Birth Gender: ☐ Male ☐ Female

B. **Student's Current Symptoms**:

1. CURRENTLY has fever/chills	☐ Yes	☐ No	
2. CURRENTLY have shortness of breath	☐ Yes	☐ No	(IF YES PLEASE CALL 911 OR GO TO ER)
3. CURRENTLY has cough	☐ Yes	☐ No	
4. CURRENTLY has chest pain	☐ Yes	☐ No	(IF YES PLEASE CALL 911 or GO TO ER)
5. New onset loss of taste or smell	☐ Yes	☐ No	
6. Body aches	☐ Yes	☐ No	
7. Nasal congestion, sore throat, runny nose	☐ Yes	☐ No	

8. Other current symptoms : _____

C. **Student's <u>Active</u> Medical Conditions:**

1. Asthma/COPD	☐ Yes	☐ No
2. Diabetes	☐ Yes	☐ No
3. Cancer	☐ Yes	☐ No
4. Autoimmune disease	☐ Yes	☐ No
5. Heart Disease	☐ Yes	☐ No

6. Other Chronic Medical Conditions: _____

C. Medications Student takes daily:

☐ Student is currently **not** on any medications

☐ Student's list of medications are : _____ _____ _____

_____ _____ _____

G. Medication student is allergic to

☐ Student has no known medication allergies

☐ Student is allergic to these medications: _____ _____ _____

C. Student's Social History:

Student lives with : ☐ Parent(s) ☐ Grandparent(s) ☐ Other: _____

Grade level : ☐ Elementary ☐ Middle ☐ High School

By placing my signature below, I hereby certify that the information I provided above about the student is true and correct.

Parent's Name: _____

Signature: _____ *Date:* _____/_____/_____