

Patient Name: _____

Date of Exam: _____

COVID-19 DISCLOSURE

- Within the past 14 days I have not tested positive for COVID-19 nor have I displayed any symptoms consistent with COVID-19 (fever, dry cough, etc.).

Patient Signature

- To the best of my knowledge, within the past 14 days, I have not been in contact with anyone who has tested positive for COVID-19.

Patient Signature

- Per the guidelines of the Louisiana Department of Health, I agree to reply *in writing* to an email from Dr. Katie Wonch regarding any changes to my COVID-19 exposure status. This email will be received 14 days from today and I will reply within 24 hours.

Email Address

Patient Signature

FOR OFFICE STAFF

Patient's entering temperature: _____

Guardian entering temperature: _____

Examiner's Initials

