Provider: FHS BBC BOR TDM

FRONTIER HEALTH AND WELLNESS

- COVID-19 Screening -

This screening is to be completed by EACH individual over the age of 18 who has entered the building with your party today. FHW is requiring this form be completed on behalf of all of its contracted medical and clinical providers.

THIS SECTION TO BE COMPLETED BY ALL PATIENTS

Yes No (circle) **I have had** any symptoms of acute respiratory infection (e.g., fever, cough, difficulty breathing) during the last two weeks.

Yes No (circle) **I have had** contact with any individual with acute respiratory infection (e.g., fever, cough, difficulty breathing) during the last two weeks.

Yes No (circle) **I have** left the State of Alaska in the last two weeks.

If you answered YES to any of the above questions

Yes No (circle) I am fully vaccinated against the COVID-19 Virus

Yes No (circle) I have had a negative COVID-19 test result since returning home or since the onset of symptoms

_____ (Initial) I decline to answer the questions listed above

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FOR PEDIATRIC PATIENTS AND THEIR PARENTS ONLY

Yes No (circle) To the best of my knowledge ALL of the above statements that I have initialed apply to BOTH by myself (the parent) and every individual who has entered the building with us today (e.g., the patient, siblings, another parent, etc).

If ANY of these above statements apply to you, then please speak with your provider before your appointment.

If you are unable to make today's scheduled appointment for this reason then we will work with you to make accommodations.

*** Please Note***

We are a medical facility so we are still requiring (regardless of vaccination status) that **masks be worn in all public areas** of the clinic. You may speak with your provider directly for their preferences while you or your child is in their individual appointment.

Thank you for your understanding and cooperation as we work to minimize the risk of COVID-19 for our patients, our staff and the community.

____
Name of patient or parent (print)

____
Signature of patient or parent

____
Date

____
Name of child (if applicable)

For Office Use Only

Patient Temp: _______ degrees

Patient Weight: _______ lbs (in office, per patient)

Patient Height: ___ft____in (in office, per patient)