BRIDGES COUNSELING
CENTER FOR CHILD & FAMILY WELLNESS

COVID-19 Health Screening

<u>For the safety of our staff and clients</u>:

Please answer the following questions prior to each in-person psychotherapy session.
By signing this document, you understand that you are agreeing to wear a protective face mask that you will provide, and that you consent to a body temperature reading from a contact-less thermometer.

Client Name (printed):_____

Date:_____ Clinician:_____

Do you or your child have any of the following:	**Yes**	**No**
Signs or symptoms of a **fever** (chills, sweats) or an actual fever over 100 F in the past 48 hrs?		
Signs or symptoms of **respiratory infection** (cough, sore throat, or shortness of breath)?		
Contact in the past 14 days with someone who has a **confirmed diagnosis** of COVID-19, who is **suspected** to have COVID-19 , or who is **ill** with a respiratory illness?		
Have travelled within the past 14 days outside of your normal routine?		
Had close contact with someone that has travelled extensively in the past 14 days?		

I attest that this form was completed to the best of my knowledge.
I understand that deliberately falsifying any information on this form could result in termination of psychotherapy treatment.

X **Client or Parent Signature**:_____

Parent Name if applicable (printed):_____