

TeeKoz Kids Screener Questions

Client Name: _____

Parent/Caregiver Present: _____

Date of Session: _____

	Date of session:
Does your child or anyone in your family have fever or have you/they felt hot or feverish recently (14-21 days)?	Yes No
Is your child or anyone in your family having shortness of breath or other difficulties breathing?	Yes No
Does your child or anyone in your family have a cough?	Yes No
Does your child or anyone in your family have any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Yes No
Has your child or anyone in your family experienced recent loss of taste or smell?	Yes No
Has your child or anyone in your family been in contact with any confirmed COVID-19 positive patients?	Yes No
Have you/they traveled in the past 14 days to any regions heavily affected by COVID-19? (as relevant to your location)	Yes No

By signing this form, I hereby attest that I have answered the above questions honestly and to the best of my knowledge and certify that my child and I are attending our in-person session under our own volition.

Parent Signature

Date

Therapist Signature

Date