Charlotte Reznick PhD

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COVID-19 PATIENT SCREENING (for each appointment during pandemic)

Office Safety Measures I am taking to protect you and your children:

- Screening clients for COVID-19 symptoms prior to their visit
- Request to wash hands for 20-30 seconds in nearby restroom before session
- Temperatures taken at the door with infrared non-touch thermometer
- Free-standing hand sanitizer for clients and their families
- Masks worn throughout our session unless parent and child are fully vaccinated
- Masks provided if a child or parent doesn't have one
- HEPA air-sanitizer always running in the office to constantly clean the air
- Frequently sanitizing often used surfaces
- Sterilizing room with a UVC Germicidal ultra-violet light multiple times daily
- Remote sessions (Zoom/FaceTime/Phone) for clients who are actively sneezing, coughing, have fever, or not feeling well

Patient Information

Name of Child/Teen _____ Parent Name _____

Do you or your child have a fever or felt hot/feverish recently (1-14 days)?	☐ Yes	☐ No
Are you or your child having shortness of breath or other breathing difficulties?	☐ Yes	☐ No
Do you or your child have a cough?	☐ Yes	☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?	☐ Yes	☐ No
Have you or your child experienced recent loss of taste or smell?	☐ Yes	☐ No
Have you or your child been in contact with any confirmed COVID-19 positive patients? Patients who are well but have a sick family member at home with COVID-19?	☐ Yes	☐ No
Have you traveled in the past 14 days to any regions affected by COVID-19?	☐ Yes	☐ No

Positive response to any of these would likely indicate a ZOOM rather than an in-person session is indicated. Let's discuss to decide on the best course of action.

For information and testing, see California's Department of Public Health Website at:
https://www.cdc.gov/publichealthgateway/healthdirectories/healthdepartments.html

PLEASE READ AND SIGN

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or child's) health. It is my responsibility to inform Dr. Reznick of any changes in medical status.

I consent to use electronic records and signatures as outlined at
www.imageryforkids.com/electronic-signature-disclosure

Signature	Relationship to Patient
Print Name	Date