

WINK OPTOMETRY COVID-19 SCREENING FORM

1. Do you have any of the following symptoms? YES NO
- a. Fever
 - b. Cough
 - c. Sore throat
 - d. Shortness of breath

2. In the past 14 days, have you had close contact with someone who is confirmed as having COVID-19? YES NO

A close contact is defined as a person who:

- a. Provided care for an individual, including healthcare workers, family members or other caregivers, or who had other similar close physical contact without consistent and appropriate use of personal protective equipment.
- b. Who lived with or otherwise had close prolonged contact (within 6 feet) with the person while they were infectious.
- c. Had direct contact with infectious bodily fluids of the person (was coughed or sneezed on) while not wearing recommended personal protective equipment.

3. In the past 14 days, have you traveled outside of the United States? YES NO

Name

Signature

Date