THE PEDIATRICIANS OF HYDE PARK

_____ _____

Patient name: Date of Birth:

1. Do you need this for any other reason than exposure?

   Please say yes or no: _____

2. Reason for testing: _____

3. Has your child had a known exposure to COVID 19?

   Please say yes or no: _____

   If yes, answer the question A-G If no, skip to number 4.

   a Date of exposure: _____

   b Relationship to positive individual: _____

   c Did your child have direct physical contact with the individual (ex: touching, hugging, kissing)?

   Please say yes or no: _____

   d Was your child within 6 feet for at least 15 minutes to this individual?

   Please say yes or no: _____

   e Was your child in an enclosed space with this individual for 30 minutes or more (ex: classroom, car, restaurant)?

   Please say yes or no: _____

   f Did the positive person have a mask on?

   Please say yes or no: _____

   g Was your child masked?

   Please say yes or no: _____

4. Has your child had any of the following symptoms, if yes please list the below: fever, cough, congestion, shortness of breath, headache, nasal congestion, nausea or vomiting, diarrhea or rash?

_____

_____

_____

Other symptoms? _____

5. Has your child previously been evaluated for covid either through testing or evaluation by another healthcare provider? Please say yes or no: _____

If yes please describe:

_____

_____

_____

6. Is there any additional information your feel important for your Doctor to know re: the exposure or need for testing?

_____

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