COSTCO PHARMACY

Immunization—Additional Screening Questions

PATIENT INFORMATION

PATIENT'S LAST NAME | PATIENT'S FIRST NAME | MI | BIRTH DATE (MM/DD/YYY)

SCREENING QUESTIONS

1. Do you currently have a fever (≥100.0 degrees F)?	☐ Yes	☐ No
2. In the past 48 hours, have you had new onset: a. fever (≥100.0 degrees F) b. persistent cough c. shortness of breath	☐ Yes	☐ No
3. In the past 48 hours, have you had any of the following symptoms? a. Chills, with or without repeated shaking b. Muscle aches c. Sore throat d. Fatigue e. Nausea f. Diarrhea g. New loss of taste or smell	☐ Yes	☐ No
4. In the past 10 days, have you had known close contact* with a person who has confirmed COVID-19?	☐ Yes	☐ No
5. In the past 10 days, have you had known close contact* with a person experiencing symptoms of COVID-19?	☐ Yes	☐ No

* "Close contact" is defined as: household member, intimate partner, caregiver or having a face-to-face conversation for 15 minutes or more within a distance of less than 6 feet

PHARMACIST DOCUMENTATION

PATIENT'S CURRENT TEMPERATURE: _____

☐ PATIENT DECLINES TEMPERATURE CHECK

PHARMACIST INITIALS: _____