مركز دوريس دوان يونج للتوحد
AUTISM CENTER
The DORIS DUAN-YOUNG

The Doris Duan-Young Autism Center
Dubai Branch, Dubai Health Care City
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HEALTH SCREENING QUESTIONNAIRE (COVID-19)

Name: _____ **Date:** ___/____/____

Mobile No: _____ **Temperature:** _____

Purpose of the Visit: _____ **Emirates ID*:** _____

In order to maintain a safe and healthy environment at The Doris Duan-Young Autism Center and the rest of our community during the COVID-19 global pandemic, we require you to complete this form regarding symptoms and history of illness prior to coming to the Center.

***Indicate Yes or No and provide relevant details.**

SCREENING QUESTIONS	YES*	NO*	COMMENTS*
Do you have a fever or experienced fever within the last 14 days?			
Do you have cough?			
Are you having shortness of breath or any difficulty breathing?			
Do you have chills?			
Do you have any muscle pain?			
Do you have any recent onset of headache or sore throat?			
Do you have any recent loss of taste or smell?			
Do you have any other flu-like symptoms?			
Is there Any member of the household experiencing any signs of respiratory infection?			
Have you travelled in the past 14-days, or been in contact with someone who recently came to the UAE within the past 14 days?			
Are you in contact with anyone (household members, neighbours, friends...etc.) who has been confirmed to be COVID-19 positive within the past 14-days?			
Have you been tested for COVID-19? If yes, when and what was the result?			
Have you recently attended any large gatherings?			

***** Note: In case of the presence of any symptoms COVID-19 infection, then entry to DDY premises will be denied.***

***** Visitors shall complete this form on each visit.***

****Visitors shall provide a copy of their Emirates ID.***

Thank you for your cooperation and will contact you if we need further information.

Signature: _____