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|  | **COVID – 19 Passport:** | **Your Name Here** |
| **(See reverse for health care person-centered profile)** |

Note: Information on this form may not be complete

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| **PERSONAL INFORMATION** |
| **First Name** | **(Nickname)** | **Last Name** | **DOB or Age** |
|  |  |  |  |
| **Street Address** | **City, State, Zip** |
|  |  |
| **Emergency Contact** | **Emergency Contact Phone/Email** |
|  |  |
| **Parent/Legal Representative** | **Parent/Legal Representative Phone/Email** |
|  |  |
| **Insurance Information** | **Pharmacy Information (Most Commonly Used)** |
|  |  |
| **Primary Care Provider/Contact Information** | **Specialty Care/Contact Information** |
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| **CURRENT SYMPTOMS/RISK FACTORS** |
| **Current COVID 19 Symptoms (Check all that apply)** | **Date Started** | **Risk Factors (Check all that apply)** | **Risk Factors (Check all that apply)** |
|  Temp. over 100.4 ° F |  |  Long-term care resident |  Cancer |
|  Dry Cough |  |  Transplant |  Age 65 or over |
|  Malaise/Fatigue |  |  COPD/Emphysema/Asthma |  Pregnant |
|  Shortness of breath |  |  Current/Former Smoker |  Severe obesity |
|  Nasal congestion |  |  Liver Disease |  HIV/AIDS |
|  Diarrhea |  |  Intellectual disability |  Kidney disease |
|  Loss of smell/taste |  |  Neurological disorder |  Homeless |
|  Sore throat |  |  Heart disease |  Chronic bronchitis |
|  Low blood oxygen |  |  Corticosteroid use |  Other |
|  Headache |  |  Mental illness/substance use |  Other |

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| --- | --- | --- |
| **HEALTH CONDITION LIST** | **MEDICATION LIST** | **ALLERGIES** |
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|  PERSON HAS DO NOT RESUSOTATE (DNR) ORDER – Location of document and/or contact information if known: |
|  PERSON HAS ADVANCE DIRECTIVE – Location of document and/or contact information if known: |
|  PERSON HAS PSYCHIATRIC ADVANCE DIRECTIVE or other Advance Crisis Planning Tool and/or has designated a Health Care Proxy decision maker – Location of document and/or contact information if known: |