

Visitor Screening Tool

Visitor's Name: _____ Date: _____

Phone Number: _____ Email: _____

Resident Being Visited: _____ Time In: _____ Time Out: _____

In the past 24 hours, have you experienced:		
New or worsening cough:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of breath or difficulty breathing:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
New loss of taste or smell:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fever (100.0°F or higher) or felt feverish: Temperature if taken: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
OR TWO (2) or more of the following:		
Chills:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Muscle aches:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sore throat:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nausea or vomiting:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congestion or runny nose:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
In the past 14 days:		
In the past 14 days have you had close contact with an individual diagnosed with COVID-19?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you have any of the above symptoms or exposures, we ask that you do not visit at this time. Self-isolate at home for a minimum of 10 days since symptoms and contact your primary care physician's office or nearest urgent care facility for direction, if needed. Please feel free to call your loved one or call our staff to check on them until your symptoms resolve.

To the best of my knowledge the above information is correct. I will notify this facility if I develop symptoms consistent with COVID-19 within 14 days after visiting.

Visitor Signature: _____ Date: _____

Thank you for your understanding and cooperation in helping us keep our residents, staff, and community safe.

Testing if applicable (to be completed by staff):

Onsite Ag Test Copy of Lab Test Not applicable at this time

Initials of Reviewer: _____