COVID19 SCREENING QUESTIONS
Visitors

Name: ________________________________

Date: __________ Time: __________ Apt Visiting: ______

Reason for Visit:____________________________

NO VISITORS ALLOWED EXCEPT THOSE PROVIDING CRUCIAL CAREGIVING SERVICES

Screening Employee: _____________________

Do you have:

Fever within past 24 hours:	Yes _______	No _______
Coughing/Sneezing	Yes _______	No _______
Sore throat	Yes _______	No _______
Shortness of breath	Yes _______	No________

And/or the following within the past 14 days:

Recent Travel to high risk areas	Yes _______	No _______
Exposure to someone with documented or suspected COVID-19	Yes _______	No _______
Resides in a community where community-based spread of COVID-19 is occurring	Yes _______	No _______

If visitors answer yes to any of these questions, do not allow them into your facility. Follow your facility's protocols for what to do next.

Please contact your supervisor if needed for additional guidance.
**All completed forms must be saved.*

3.11.20