VISITOR
Screening Questions for COVID-19
This form should be completed and left in the main office.

Visitor Name: ________________________________ Phone: __________________

Date: ___________ Purpose of Visit/Person Visiting: __________________________

1. Do you have any of these symptoms that are **not caused by another condition**? Circle the condition if YES or check NO.

   - □ YES  □ NO
   - Fever or chills (100.4F)
   - Cough
   - Shortness of breath/difficulty breathing
   - Fatigue
   - Diarrhea
   - Muscle or body aches
   - Headache
   - Chills
   - Recent loss of taste or smell
   - Sore throat
   - Congestion/runny nose
   - Nausea or vomiting

2. Within the past 14 days, have you had contact with anyone that you know has COVID-19 or COVID-like symptoms? Contact is defined as being 6 feet or closer for more than 15 minutes or having direct contact with fluids from a person with COVID-19 (for example, through that person’s coughing or sneezing).

   - □ YES  □ NO

3. Within the past 14 days, has a public health or medical professional told you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection?

   - □ YES  □ NO

Visitor Signature: ____________________________________________________________