John Bapst 1928

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: _____