Visitor Screening

Name of visitor _____ Title/License _____

Visiting which resident? _____ Date of Visit _____

1. Do you have or have you had any of the following symptoms in the past 14 days?
   - ❑ Fever greater than 100 degrees / current temperature is _____ (staff verified)
   - ❑ Difficulty breathing
   - ❑ Cough
   - ❑ Sore Throat
   - ❑ Chest pain or pressure

If you checked any of the above, please do not enter and understand this is necessary to prevent any possible exposure to our staff and residents.

2. Do you travel to or work at multiple facilities? ❑ Yes ❑ No If no, proceed to number 6. If yes, please list those facilities:

   _____ _____

   _____ _____

   _____ _____

3. Has any facility you've visited or worked at have a person with COVID-19? ❑ Yes ❑ No

4. Do/did you change clothing between locations, or did you wear a disposal gown? ❑ Yes ❑ No

5. Do/did you wear any personal protective equipment at the facilities or locations you visited? ❑ Yes ❑ No If so, identify the PPE worn _____

6. Have you been tested for COVID-19? ❑ Yes ❑ No If yes, were the results positive? ❑ Yes ❑ No

7. Have you traveled to another state or country in the past 14 days? ❑ Yes ❑ No

8. To your knowledge, have you had contact with anyone confirmed to have COVID-19 in the past 14 days? ❑ Yes ❑ No

The facility will test anyone entering for signs and symptoms of respiratory infection. This will include obtaining a temperature. If after visiting this facility, should you develop any signs or symptoms that could be or are related to COVID-19, please notify the facility immediately telling management the date and time you were present and which resident(s) you visited.

Do you agree with notification mandate? ❑ Yes ❑ No

Sign _____ Date_____ Phone # _____

Print your name _____

Company name, if applicable _____

Please do not continue into the facility until this form has been reviewed by management and/or staff.

Staff screener's initials _____