COVID-19 Screening Tool – Visitation Version 6-19-2020

Name____________________ **Date____________** **Time________**

Name of Resident You Are Visiting:____
Your Phone Number and email address :____________________________________

1. Do you have any respiratory signs/symptoms? **Check all that apply**:
   a. Fever ________
   b. Cough ________
   c. Sore Throat ________
   d. Shortness of Breath ________
   e. Chills ________
   f. Repeated shaking with chills ______
   g. Muscle Pain ________
   h. Headache ________
   i. Loss of taste or smell ________

   If yes to any of the above, you will not be able to visit until free of signs/symptoms.

2. I have performed hand hygiene with Hand Sanitizer or washed hands with soap and water for at least 20 seconds prior to visitation?

   ☐ Yes (please check box)

   Must be witnessed and answer "Yes" – if you refuse, please leave.

3. Have you had close contact with a laboratory-confirmed COVID-19 person in the last 14 days?

   ___________Yes ___________No

   If yes, you will not be allowed to visit.

4. Temperature at Sign in: ___________

   If temp > 99.0 please leave the building.

I have answered these questions truthfully. If while visiting I become ill with any of the above symptoms, I will inform Clark and leave the premises.

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Sign-In Signature