Visitor Screening Tool

Visitor's Name: _____ **Date:** _____

Phone Number: _____ **Email:** _____

Resident Being Visited: _____ **Time In:** _____ **Time Out:** _____

In the past 24 hours, have you experienced:		
New or worsening cough:	☐ Yes	☐ No
Shortness of breath or difficulty breathing:	☐ Yes	☐ No
New loss of taste or smell:	☐ Yes	☐ No
Fever (100.4°F or higher) or felt feverish: Temperature: _____	☐ Yes	☐ No
OR TWO (2) or more of the following:		
Chills:	☐ Yes	☐ No
Muscle aches:	☐ Yes	☐ No
Headaches:	☐ Yes	☐ No
Sore throat:	☐ Yes	☐ No
Diarrhea:	☐ Yes	☐ No
Nausea or vomiting:	☐ Yes	☐ No
Congestion or runny nose:	☐ Yes	☐ No
In the past 14 days:		
In the past 14 days have you had close contact with an individual diagnosed with COVID-19?	☐ Yes	☐ No

If you have any of the above symptoms or exposures, we ask that you do not visit at this time. Self-isolate at home for a minimum of 10 days since symptoms and contact your primary care physician's office or nearest urgent care facility for direction, if needed. Please feel free to call your loved one or call our staff to check on them until your symptoms resolve.

To the best of my knowledge the above information is correct. I will notify this facility if I develop symptoms consistent with COVID-19 within 14 days after visiting.

Visitor Signature: _____ Date: _____

Thank you for your understanding and cooperation in helping us keep our residents, staff, and community safe.

Test Results if applicable (to be completed by staff)**:**

- ☐ Onsite Ag Test _____
- ☐ Copy of Lab Test Date: _____
- ☐ Not applicable at this time

Initials of Reviewer: _____

ICHD 3/3/21