



VISITOR SCREENING Questionnaire

No Yes

- I have traveled to an area that is currently restricted by state order within the last 14 days.
- I have been in close contact with people who have traveled to countries where COVID-19 is spreading within the past 14 days.
- I have been around people who are sick with colds or flu.
- I have symptoms of a cold.
- I have a fever, or have had a fever within the past week.

If you have marked yes to any question, please postpone your visit for at least 14 days after the start of your symptoms.

Contact your healthcare provider if your symptoms get worse. Thank you for understanding.

First and Last Name

Signature

Email Address (if available)

Daytime and Evening Phone Number

Physical Street Address

Date/Time of Visit

Vendor (if applicable)

- I refuse to complete this form, and understand I will not be able to enter the facility.

RETURNING VISITORS:

Have any symptoms changed in the last seven days? NO | YES

If yes, please explain _____

Date/Time of Visit _____

FOR OFFICE USE ONLY

The person above has been cleared for visitation. Initials _____ Date/Time _____