PROTECT AGAINST
COVID-19

Heritage

ASSISTED LIVING

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.
☐	☐	In the past seven days, I have had a fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea
☐	☐	I have a fever, or have had a fever within the past week (100°F or above).
________		Current temperature

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

____
Purpose of Visit

____
Name of Resident Visiting

____
Vendor (if applicable)

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

Notes ____

FOR **OFFICE USE ONLY**

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

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