

Visitor Health Screening Entry Form

Visitor Name _____ Date _____

Screener Name _____ Date _____

Have you had any of the following since the last time you were here? (check any that apply):

- Testing for COVID-19.
- A fever of 100.4 or higher or a sense of having a fever.
- A cough that you cannot connect to another health problem.
- Shortness of breath that you cannot connect to another health problem.
- A sore throat that you cannot connect to another health problem.
- Diarrhea.
- Muscle aches that you cannot connect to another health problem or activity, such as physical exercise.
- Does anyone in your household have any of the above signs/symptoms right now?
- Have you had close personal contact with anyone confirmed or suspected with COVID-19?