Visitor Screening Tool

DATE OF SCREENING:_____**TIME ARRIVED:**_____ **TIME LEFT:**_____

NAME OF SCREENER:_____ **SIGNATURE OF SCREENER:**_____

NAME OF VISITOR:_____ **SIGNATURE OF VISITOR:**_____

TEMP:_____ **RESIDENT VISITED:**_____
(Temp must be less than 100^{0}F)

SCREENING QUESTION	YES	NO	DECISION FOR ENTRY
Have you tested positive for COVID-19? • If YES, when was that test done?_____			**If YES and it has been fewer than 2 weeks ago - STOP, please see IP for direction.**
SCREENING QUESTION	**YES**	**NO**	**DECISION FOR ENTRY**
Have you had close contact with someone who has tested positive for COVID-19 within the past 14 days WITHOUT wearing proper PPE?			**If YES - STOP, please see IP for direction.**
SCREENING QUESTION	**YES**	**NO**	**DECISION FOR ENTRY**
Are you currently ill?			**If YES - STOP, please see IP for direction.**
SCREENING QUESTION	**YES**	**NO**	**DECISION FOR ENTRY**
Do you have symptoms of a cold, cough, shortness of breath, or temporarily lost your sense of taste or smell? Do you have symptoms of nausea/vomiting or diarrhea?			**If YES - STOP, please see IP for direction.**
SCREENING QUESTION	**YES**	**NO**	**DECISION FOR ENTRY**
Do you currently have a fever, or have you had a fever or felt like you had a fever in the past 24 hours without taking fever reducing medications?			**If YES - STOP, please see IP for direction.**
SCREENING QUESTION	**YES**	**NO**	**DECISION FOR ENTRY**
Do you live with someone who has been a close contact and in quarantine due to a COVID-19 exposure?			**If YES - STOP, please see IP for direction.**

It is the responsibility of every visitor to notify the facility of any signs/symptoms of illness as noted above, or any contact/exposure of a confirmed COVID-19 case.