Facility Staff/Visitor Questionaire

(to protect residents against COVID-19 and other respiratory illnesses)

Name of Staff / Visitor: _____

Date: _____ Time: _____ a.m. / p.m.

Do you currently have a respiratory-related illness?	❑ YES	❑ NO
Do you have a fever?	❑ YES	❑ NO
Do you have a cough?	❑ YES	❑ NO
Do you have a sore throat?	❑ YES	❑ NO
Do you have a runny nose?	❑ YES	❑ NO
Are you short of breath?	❑ YES	❑ NO
Have you been out of the country in the last 14 days?	❑ YES	❑ NO
Have you been in contact with anyone in the last 14 days who recently traveled out of the country?	❑ YES	❑ NO
I agree to wash my hands and wear a mask for the duration of my visit to safeguard the residents and care staff from the possible spread of infection.	☑ YES	

_____

Signature

Staff Use Only

Does Staff or Visitor show visible signs of a respiratory infection (cough, shortness of breath, runny nose, sneezing, etc.)? ❑ YES ❑ NO

If yes, list symptoms observed:

Current Temperature (F): _____

CHECK ONE:

❑ Refused Entrance: 2 or more "YES" answers above

❑ Refused Entrance: Fever >100F and/or visible signs of respiratory infection

❑ Allowed Entrance: No Fever >100F and no visible signs of respiratory infection

_____ _____

Staff Name / Signature Date

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