



Visitor Screening Questionnaire Notice to be posted at all building entrances

In an effort to protect our residents, clients, and patients, from illness we are screening visitors and volunteers. Please answer the following questions:

Within the past 14 days, I have traveled to a location
Where COVID-19 has been diagnosed or suspected. Yes No

Within the past 14 days, I have been in close contact
with persons who have traveled to a location where
COVID19 has been diagnosed or suspected. Yes No

Within the past 14 days, I have been sick
with a cold or the flu. Yes No

Within the last 7 days, I have had a fever. Yes No

Within the last 7 days, I have had nausea and
vomiting. Yes No

Within the last 7 days, I have had diarrhea. Yes No

I now have symptoms of a cold or flu. Yes No

I now have a fever. Yes No

Within the past 14 days, I have been around people
who have been or are sick with colds or flu. Yes No

Within the past 14 days, I have been around people
who were sick with colds or flu. Yes No

I have been nauseated or have vomited
or had diarrhea within the past week. Yes No

**IF YOU HAVE MARKED “YES” TO ANY OF THESE QUESTIONS, PLEASE
POSTPONE YOUR VISIT FOR AT LEAST 14 DAYS FROM THE DAY YOUR
SYMPTOMS BEGAN**

Thank you for your understanding