Health Screening Questionnaire: Updated 7_6_20

In an effort to protect our residents, staff, and families from infectious diseases (flu, Coronavirus, Norovirus, C. Diff, etc.), all persons entering the facility must complete the following questionnaire. Please see the receptionist, Manager on Duty, or Charge Nurse before proceeding to visit or reporting to work.

Date of Entrance:	Time of Entrance:	What is your purpose for visiting?
Name:	Phone:	Email:

Question	Answer
In the last 14 days, have you traveled out of state or internationally (exclude commuting to work or essential living activities close to home if bordering a state close by)?	☐ Yes (Visitor wear mask/Staff wear mask and face shield for 14 days) ☐ No
In the last 14 day, have you been exposed to anyone confirmed to have COVID-19 or someone under investigation for COVID?	☐ Yes (If yes, do not enter) ☐ No

In the last 14 days, do you have a NEW onset of any of the following symptoms?______________________Temp

- ☐ Fever above 100.0 F
- ☐ Shortness of Breath/Difficulty Breathing
- ☐ Cough
- ☐ Sore throat
- ☐ Headache
- ☐ Conjunctivitis, Altered Taste or Smell
- ☐ Nausea, Vomiting, or Diarrhea
- ☐ Lower Respiratory symptoms
- ☐ Chills, Fatigue, Muscle/Body Aches
- ☐ Congestion or Runny Nose
- ☐ Other ______
- ☐ None of the above

If any of the above are checked, please explain (if yes, restrict from building) (follow 14-day self-quarantine for visitors or infection policy for staff).

Question	Answer
[If Healthcare Worker] In the last 14 days, has the staff worked in facilities or locations with recognized COVID-19 Cases.	☐ Yes (If yes, do not enter) ☐ No
Has the visitor/staff washed their hands or used ABHR upon visiting?	☐ Yes ☐ No
Has the visitor/staff been instructed to NOT shake hands, touch, or hug individuals during visit unless providing needed care activities?	☐ Yes ☐ No
In the last 14 days, have you been in contact with someone who has traveled from out State, Internationally or by air?	☐ Yes (Contact Administrator) ☐ No

Visitors **(allowed for end-of-life situations)**	**Staff**
☐ Must wear a facemask while in the building and restrict visit to resident's room or other location designated by the facility staff.	☐ When no positive COVID-19 cases in facility, all staff wear facemasks while in this facility for asymptomatic residents (Change for Ill Residents). Follow Extended/reuse guidance policy. (Note: IA staff wear face shield at all times.)
Screener Signature: Nurse Signature:	Approved to visit: ☐ Yes ☐ NO

I warrant that the above information is accurate. If I experience any of the above symptoms in the next 48 hours or if I am notified that I have been exposed to a person with confirmed COVID-19 in the 14 days prior to my visit, I will notify the facility immediately.

Signature: ____ Date: ______________