VISITOR QUESTIONNAIRE (Self Screening Questions)

Name _____

Phone number: _____

Time in:_____ Time Out: _____

	Please complete all questions below	NO	YES
1	Have you recently traveled to outside the country or to an area with known local COVID-19 spread? If yes, specify country _____		
2	Have you come into close contact (within 6 feet) with someone who has a laboratory confirmed COVID-19 diagnosis in the past 14 days?		
3	Do you have or have had any of the following symptoms in the last 14 days?		
	Fever		
	Cough		
	Difficulty breathing or Shortness of breath		
	Chills		
	Sore throat		
	Body aches/Muscle pain		
	Fatigue		
	New loss of taste or smell		
	Diarrhea or Stomach pain		

If you answered YES to any of these questions then it is our humble request that you do not enter the building and contact your health care provider for questions/concerns, assessment, testing and follow up. Please only return per guidance from your treating clinician/local health authority.

Sign_____ Date_____

(To complete, sign and document if mandated by per your local guidance)