ADULT CARE HOME STAFF/VISITOR SCREENING FORM

DATE:____

NAME:____ Check: STAFF____VISITOR____

PHONE:( )____________________________

Please indicate if any of the following applies to you:

	YES	***NO***
Do you currently have a fever of 99.6° or more?		
Do you have any respiratory symptoms such as cough or shortness of breath?		
Did you have a recent diagnosis of pneumonia or flu?		
Have you travelled internationally or on a cruise ship in the last 14 days?		
If yes, list where:		
Have you had contact with anyone who has confirmed or is under investigation for Coronavirus within the last 14 days?		

I hereby certify that the information contained herein is true, accurate and correct to the best of my knowledge and belief.

Employee/Visitor Signature **Date**

If you answered YES to any of these questions, please call the supervisor in charge or administrator and report your answers.

Please leave this form in the designated location BEFORE you enter your work area.

Thank you for your cooperation and understanding as we work to maintain the safety of our residents, staff and community.