

INFECTIOUS DISEASE VISITOR SCREENING FORM

Visitor's Name _____

Date of Proposed Visit _____

Question	Response	
	YES	NO
Have you been unwell at any time during the last 14 days? <i>This relates to any type of illness, not just those symptoms associated with an infectious disease (i.e. COVID-19).</i>		
Do you or any of your household members currently have any of the following symptoms? <i>Fever, cough, sore throat, chest pain, chills, muscle aches, shortness of breath, other respiratory conditions or breathing difficulties.</i>		
Have you travelled outside your state of residence or been in a known infectious disease hot spot in the last 14 days?		
Have you or any of your household members visited a country currently listed with a CDC Level 2 or 3 travel warning within the last 14 days? https://wwwnc.cdc.gov/travel/notices		
Have you been in contact with a person with symptoms of an infectious disease or a confirmed case in the last 14 days?		

I declare that I have answered the above questions truthfully and to the best of my knowledge.

Signature/Date

On the day of your planned visit, you must be free of fever (100.4° F [37.8° C] or greater using an oral thermometer) and any other symptoms for at least 24 hours, without the use of fever-reducing or other symptom-altering medicines. This is for the safety of other occupants of the building, to avoid transmission of any communicable illness at this time of heightened sensitivity to these conditions. We appreciate your understanding.

Decision YES / NO

Signature _____