VERIFICATION of COVID-19 / SCREENING FOR ON-SITE VISITORS

Visitor Name: ___________________________

Date Visiting: ___________________

- Are you experiencing any of the following symptoms: fever, cough, shortness of breath, sore throat, loss of taste or smell or diarrhea?
  Yes or No

- Do you have a fever today? Yes or No Temperature_____________

- Have you had any close contact in the last 14 days with someone with a diagnosis of COVID-19? Close contact means a household member, or someone within six feet for ten minutes or longer. Yes or No

- Have you traveled anyplace nationally or internationally within the past 14 days that is identified by the CDC as potentially unsafe or high risk?
  Yes or No

- Have you been directed or told by the local health department or your healthcare provider to self-isolate or self-quarantine? Yes or No

If you answered yes to any of these questions or have a fever above 100.4F you will not be permitted access to the building until you are able to answer No to all questions. Typically, this would mean a 14-day period of time before you can enter the building.

You are signing this form under the penalty of perjury.

_________________________ _______________

Visitor Signature Date