**Visitor Screening Form**

Visitor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date and Time of Visit: \_\_\_\_\_\_\_\_, 2020 \_\_\_\_\_\_\_ a.m./p.m.

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Resident Visited: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a positive COVID-19 test? Yes No If yes, what was the date of the positive test? \_\_\_\_\_\_\_

Have you had any of the following symptoms in the past 72 hours?

* Fever (≥100.4°F) Nausea or Diarrhea Chills/Shaking with Chills
* Cough Muscle Aches or Pains Sore Throat
* Shortness of Breath New Loss of Taste or Smell Headache
* Fatigue Congestion or Runny Nose

Have you been exposed to anyone with a positive COVID-19 test or any of these symptoms? Yes No

If yes, document date of exposure and circumstances: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Visitor’s Temperature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ° F

**Acknowledgment**

By my signature below, I certify that my responses to the questions above are true and accurate to the best of my knowledge. I understand that if any of the responses are knowingly false when made that my visitation privileges will be revoked. I express my understanding and agreement to do the following, as conditions of visitation:

* I understand I must wear a face mask at all times during my visit. If visiting a resident that is bed-bound, I understand I must wear a face mask, gown and gloves at all times during my visit.
* I understand that I must remain at least six feet away from the resident during visitation.
* I understand I may not hug, kiss, shake hands with, or touch the resident during visitation.
* I understand I must clean my hands with alcohol-based hand rub or by handwashing before and after my visit.
* I understand I may not eat or drink during my visit.
* I understand that if I develop any of the above-identified symptoms of COVID-19 or test positive for COVID-19 within 48 hours of my visit I must notify the facility immediately.
* I understand that if I am notified I was exposed to a person prior to my visit that tested positive for COVID-19 I must notify the facility immediately.
* I understand that I will be escorted to the visitation area, I must remain in the visitation area, and I may not enter any other parts of the facility.
* I understand that the visitation will be monitored in order to observe adherence to these conditions, and if I fail to abide by any of these conditions of visitation the privilege of visitation will be revoked.
* I understand that SARS-CoV-2, the virus responsible for COVID-19, is a highly transmissible virus and long-term care facilities by nature house persons who are highly susceptible to COVID-19 and account for a large portion of morbidity and mortality related to COVID-19. As a result, visitation by persons outside of a long-term care facility with residents of that facility presents an increased risk of virus transmission and negative outcomes. By choosing to visit, I voluntarily assume all risks related to exposure to COVID-19 on my own behalf and on behalf of the resident that I am visiting.

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Signature of Visitor Date