

VISITOR COVID-19 (CORONAVIRUS) QUESTIONNAIRE

ALL VISITORS MUST COMPLETE THIS QUESTIONNAIRE EACH TIME YOU VISIT THE HOME.

NAME _____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

DAYTIME PHONE _____ EVENING PHONE _____

EMAIL ADDRESS _____

RESIDENT _____ ROOM _____

1) Do you now, or in the last 48 hours display any of the following symptoms?

Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Coughing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sore Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sneezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Congestion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Body Aches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Feeling Tired	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diminished sense of taste and/or smell	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

2) Have you travelled internationally within the last 14 days? ☐ Yes ☐ No

3) If you have travelled to any of the states included in the NY State travel advisory, have you quarantined for 14 days since your return to NY State? (See posted list of States)

☐ Yes ☐ No ☐ I have not travelled to any included states

IF YOU ANSWERED "YES" TO ANY QUESTION(S) ABOVE, OR FAIL TO COMPLETE THIS FORM IN ITS ENTIRETY, YOU WILL BE PROHIBITED FROM VISITING.

YOU MUST FOLLOW ALL ESTABLISHED PROTOCOLS. FAILURE TO DO SO WILL RESULT IN THE IMMEDIATE TERMINATION OF YOUR VISIT.

BY MY SIGNATURE, I ATTEST THAT THE ANSWERS PROVIDED ABOVE ARE TRUE AND ACCURATE

SIGNATURE _____

DATE _____

TIME _____

TEMPERATURE _____

☐ This form has been completed in its entirety and all answers are recorded as "No"