VISITOR COVID-19 (CORONAVIRUS) QUESTIONNAIRE

ALL VISITORS MUST COMPLETE THIS QUESTIONNAIRE EACH TIME YOU VISIT THE HOME.
(PLEASE PRINT CLEARLY)

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	☐ Yes	☐ No	Coughing	☐ Yes	☐ No
Sore Throat	☐ Yes	☐ No	Sneezing	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No	Respiratory Congestion	☐ Yes	☐ No
Body Aches	☐ Yes	☐ No	Feeling Tired	☐ Yes	☐ No
Diminished sense of taste and/or smell				☐ Yes	☐ 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?

☐ 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"

Staff Member Signature _____ Date _____