LEADERS COVID-19 VISITATION SCREENING CHECKLIST

1. Have you had a fever (above 100.4)
    a. Have you felt like you have had a fever in the past 24 hours?
    b. Temperature taken with temporal thermometer _____
2. So, do you have a new or worsening cough today?
    a. Yes _____
    b. No _____
3. Do you have any of the following symptoms:
    a. Shortness of breath or difficulty breathing Yes _____ No _____
    b. Fatigue Yes _____ No _____
    c. Muscle or body aches Yes _____ No _____
    d. Headache Yes _____ No _____
    e. New loss of taste or smell Yes _____ No _____
    f. Sore Throat Yes _____ No _____
    g. Congestion or runny nose Yes _____ No _____
    h. Nausea or vomiting Yes _____ No _____
    i. Diarrhea Yes _____ No _____

For Health Care Providers

Ask if they have worked in facilities or locations with recognized COVID-19 cases?

Yes _____

- If yes, ask them if they have been in close contact or worked with a person(s) with confirmed COVID-19 in the last 14 days?
- If yes restrict from visitation and location

No _____

- If no the visit will proceed.

Print Name: _____

Signature: _____

Staff Name: _____

Staff Signature: _____

Date: _____ Time: _____ a.m. / p.m.