Coronavirus (COVID-19)  
Signs & Symptoms Screening  

Name: ______________________________ Date: ___________ Best  

Contact Number: (____) ______________  

Check one:   ___ Resident   ___ Guest   ___ Employee  

If Guest: Name of resident(s) visiting? ________________________________  

1) Have you or someone you are in close contact with traveled outside the US in the last 30 days?  ____YES  ____NO  

*If YES, please refrain from visiting for a minimum of 14 days after you or your close contact has returned to the U.S. and are confirmed as not having any signs or symptoms of the Coronavirus (COVID-19), cold or flu like symptoms for at least 72 hours.  

2) Have you or someone you are in close contact with tested positive for the Coronavirus in the last 30 days?  ____YES  ____NO  

*If YES, please refrain from visiting for a minimum of 14 days after you or your close contact are no longer positive for the Coronavirus (COVID-19) and are free from any signs or symptoms of the Coronavirus (COVID-19), cold or flu like symptoms for at least 72 hours.  

3) If NO to #1 & #2, are you experiencing any of the following symptoms:  
   a. Fever (current temperature is: ________)  ____YES  ____NO  
      *fever is considered 99.5 degrees or above  
   b. Sore throat  ____YES  ____NO  
   c. Cough  ____YES  ____NO  
   d. Shortness of breath  ____YES  ____NO  

*If yes to any of #3 questions, please refrain from visiting/working until receiving a thorough clinical evaluation (please note below) or you are confirmed as no longer having any signs or symptoms of the Coronavirus (COVID-19), cold or flu like symptoms for at least 72 hours.  

Notes:  
_____________________________________________________________________________  
_____________________________________________________________________________