Daily Visitor Health Screening Form

This form must be completed by all visitors upon arrival at the facility. Please print clearly and answer all questions honestly to help ensure the health and safety of everyone in our building.

Visitor Information

Date:
MM/DD/YYYY

Time of Arrival:
HH:MM AM/PM

Full Name:

Phone Number:

Email Address:

Name of Person / Department Visiting:

Temperature (if taken at entry):
Degrees Fahrenheit/Celsiu

Health Screening Questions

Please type "YES" or "NO" in the text box for each of the following questions:

1. Are you currently experiencing any symptoms of illness (such as fever, cough, shortness of breath, sore throat, muscle aches, or new loss of taste or smell)?
YES or NO

2. In the past 14 days, have you been in close contact with anyone who has tested positive for COVID-19 or any other highly contagious infectious disease?
YES or NO

3. Have you traveled internationally or to any high-risk areas subject to quarantine mandates in the last 14 days?
YES or NO

4. Are you currently under any official order to self-quarantine or self-isolate?
YES or NO

Acknowledgment & Signature

By signing below (or typing your name for digital printouts), you certify that your responses are true and correct to the best of your knowledge.

Printed Name:

Signature (or Written Signature on Printed Copy):
Sign on the line when print

Date Signed:
MM/DD/YYYY