Hospital Visitor Infection Screening Checklist

Please complete this checklist prior to entering patient care areas to help maintain a safe environment for all patients, staff, and visitors.

Visitor Information

Visitor Full Name:

Contact Phone Number:

Date (MM/DD/YYYY):

Patient Name to Visit:

Patient Room / Unit Number:

Symptom Screening

Please write "Yes" or "No" for each of the following symptoms experienced within the last 48 hours:

1. Fever (100.0Â°F / 37.8Â°C or higher) or chills:
Yes or No

2. New or worsening cough:
Yes or No

3. Shortness of breath or difficulty breathing:
Yes or No

4. Sore throat, runny nose, or nasal congestion:
Yes or No

5. New loss of taste or smell:
Yes or No

6. Muscle/body aches, headache, or unusual fatigue:
Yes or No

7. Nausea, vomiting, or diarrhea:
Yes or No

Exposure History

Please write "Yes" or "No" for the following questions:

Have you had close contact in the past 10 days with anyone diagnosed with or suspected of having an infectious respiratory illness (e.g., COVID-19, Influenza)?
Yes or No

Have you been advised by a public health authority or healthcare provider to self-isolate or quarantine at this time?
Yes or No

Visitor Acknowledgment

I certify that the information provided above is accurate to the best of my knowledge.

Visitor Signature (For print, sign on line. For digital, type name):

Time of Entry (HH:MM AM/PM):