MARK ANDY

COVID-19 VISITOR QUESTIONNAIRE

	YES	NO
1) Have you been in close contact with anyone with either a confirmed case of COVID-19 OR who has symptoms of COVID-19 in the past 14 days?	☐	☐
2) In the last 48 hours, have you had any of the following symptoms? a. Fever of 100^{O} F (37.8^{O} C) or above, or possible fever symptoms like alternating chills and sweating b. Cough c. Trouble breathing, shortness of breath or severe wheezing d. Chills or repeated shaking with chills e. Muscle aches, fatigue, body aches f. Sore throat, congestion, or runny nose g. Loss of smell or taste, or a change in taste h. Nausea, vomiting or diarrhea i. Headache	☐	☐
3) Have you had a positive COVID-19 test for active virus in the past 10 days?	☐	☐
4) Has a public health official advised you to get tested for COVID-19?	☐	☐
5) Within the past 14 days, has a public health or medical professional told you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection?	☐	☐
6) Do you agree to wear a mask at all times while in the facility and maintain a social distance of at least 6 feet from others?	☐	☐

I CERTIFY THAT THE ABOVE STATEMENTS ARE ALL TRUE AND ACCURATE AS OF THE DATE BELOW

_____

Signature Date

_____

Name (Printed)