



COVID 19- Visitor Screening

Individual Receiving Visitor(s): _____

Staff Supervising Visit: _____

Date & Time of Visit: _____

Visitor 1 Name: _____ Visitor 1 Temperature Reading: _____

Visitor 2 Name: _____ Visitor 2 Temperature Reading: _____

If a visitor answers **Yes** to any of the questions below, the visit should NOT occur and the visitor will need to leave.

	Visitor 1		Visitor 2	
	Yes	No	Yes	No
Symptom Screening				
I have symptoms of a respiratory infection				
I have a fever				
I have a cough				
I have shortness of breath				
I have a sore throat				
I have any other of the following symptoms- diarrhea, loss of smell or taste, chills, headache, body aches, abdominal pain, or vomiting				

	Visitor 1		Visitor 2	
	Yes	No	Yes	No
Exposure Screening				
During the last 14 days, I was exposed to someone for more than 10 minutes with any of the symptoms above.				
During the last 14 days, I was exposed to someone for more than 10 minutes who was diagnosed with COVID-19.				
During the last 14 days, I traveled outside of Massachusetts.				
During the last 14, I was in close contact in a large group setting (10 or more people).				

Any individual who participates in a visitation and develops signs and symptoms of COVID-19 as outlined above within 2 days after the visitation must immediately notify the program.

Visitor 1 Signature _____ Visitor 2 Signature _____ Date _____

Staff Signature _____ Date _____

Once the visit is completed, staff should send all completed screening forms to Kristin Carlander or Mae McNamara.