**Visitor Screening Form for COVID-19**

**(Use for contractors and everyone else not an employee entering the facility)**

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| Facility Name: | | | |
| Visitor’s Name: Name/Location Visit: | | | |
| Date of Screen: Age of Visitor: | | | |
|  | | | |
| **Recent History** | | | |
| Have you or any person with whom you have close contact traveled outside of the U.S in the last 21 days? \_\_\_\_\_\_Yes \_\_\_\_\_\_No  If so, which country, including lay over? | | | |
| Have you traveled to China, Italy, Iran or South Korea (including lay over) within 14 days \_\_\_\_Yes \_\_\_\_No | | | |
| Have you been in any states other than Missouri in the last 21 days? \_\_\_\_\_ Yes \_\_\_\_\_ No  If so, which states? | | | |
| Have you had close contact with any individual with a laboratory confirmed COVID-19 or Patient Under Investigation (PUI) for COVID-19? \_\_\_\_\_\_ Yes \_\_\_\_\_\_No  ***Close contact*** *is defined as being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time (15 to 30 minutes). Close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case or having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on).* | | | |
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| **Symptom Assessment** | | | |
| Do you have any of the following symptoms? | | | |
|  | Yes | No | Describe |
| Fever |  |  |  |
| Dry cough |  |  |  |
| Shortness of breath |  |  |  |
| **If the visitor has any of the above, please ask them to return home and contact their health care provider for further treatment recommendations.** | | | |
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| **Notes, if any:** | | | |
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| Name of person completing the assessment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |