Facility name: _____ Date/Time: _____

Screener name: _____ Visitor name: _____ Visitor phone #: _____

Resident name: _____

COVID-19 Screening Assessment

	(circle)	Comments/Questions
Does the screener observe any signs or symptoms of a respiratory infection, such as a fever, cough, shortness of breath?	Yes No	
Does the visitor report any potential signs or symptoms of a respiratory infection, such as fever, cough, shortness of breath?	Yes No	
In the last 14 days, has the visitor had contact with someone with a confirmed diagnosis of COVID-19 or under investigation for COVID-19?	Yes No	
Has the visitor traveled to any locations with current COVID-19 transmissions within the last 14 days?	Yes No	
Has the visitor resided in a community where a community-based spread is occurring?	Yes No	