Bethel Nursing & Rehabilitation Center

VISITORS SCREENING/QUESTIONNAIRE FOR COVID-19

NAME: _____ DATE: _____ TIME: _____
ADDRESS: _____
DAYTIME PHONE: _____ EVENING PHONE: _____
EMAIL ADDRESS: _____
NAME OF RESIDENT VISITED: _____
COVID – 19 TEST RESULTS PROVIDED: DATE OF TEST :_____ . NEGATIVE RESULTS____Y ____N

HAVE YOU BEEN VACCINATED: _____Y _____N BOTH DOSES (IF 2 DOSE) _____Y _____N

PLEASE CHECK BELOW AS APPROPRIATE	YES	NO
DO YOU HAVE FEVER? (Record Temperature)		
DO YOU HAVE COUGH?		
DO YOU HAVE SHORTNESS OF BREATH?		
DO YOU HAVE SORE THROAT?		
DO YOU HAVE RUNNY NOSE/CONGESTION?		
DO YOU HAVE HEADACHE?		
DO YOU HAVE NAUSEA & VOMITING?		
DO YOU HAVE DIARRHEA?		
DO YOU HAVE MYALGIA? (MUSCLE ACHES)		
DO YOU HAVE CHILLS?		
DO YOU HAVE LOSS OF SMELL OR TASTE?		
HAVE YOU TRAVELLED INTERNATIONALLY IN THE LAST 10 DAYS?		
HAVE YOU BEEN EXPOSED TO ANYONE WITH POSITIVE OR PRESUMED COVID IN THE LAST 14 DAYS?		
HAVE YOU TESTED POSITIVE FOR COVID-19 IN THE LAST 14 DAYS?		

I have been provided with the CDC informational sheet on COVID-19

My signature indicates that the above questions are answered truthfully

SIGNATURE: _____

PLEASE TAKE NOTE. IF FEVER (100.0) OR SYMPTOMS INDICTING RESPIRATORY INFECTION, YOU CANNOT VISIT. THANK YOU.

4/1/21