**Health Screening Form for Visitors**

In an effort to reduce the risk of COVID-19 exposure to XX’s employees, all visitors must complete the following screening questions:

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Visitor’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Visitor’s phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person/department visiting: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Self-Declaration by Visitor** | | |
|  | **YES** | **NO** |
| Have you traveled to out of the country or been in close contact with anyone who has traveled out of country within the last 14 days? |  |  |
| Have you had close contact with or cared for someone diagnosed with COVID-19 within the last 14 days? |  |  |
| Have you experienced any cold or flu-like symptoms in the last 14 days (fever, cough, shortness of breath or other respiratory problem)? |  |  |

Visitors answering yes to any of the above questions will not be permitted access to XX’s facility.

Visitor signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For internal use:**

Access to facility (circle one): Approved Denied

Employee name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_