SEQUOIA LIVING℠
Life Services for Seniors

Visitation Screening Form

Person Entering Community: _____ Date: _____

Name of resident you are seeing: _____

QUESTION	YES	NO
Any international travel or domestic travel outside the Bay Area within the past 14 days?		
Have you had contact with a person who has or is suspected of having COVID-19 within the past 14 days?		
Have you had close contact or taken care of anyone with cough, fever, shortness of breath, or sore throat within the past 14 days?		
Have you or anyone in your household cared for someone diagnosed with COVID-19?		
Do you live with or have close contact with anyone who has been tested or will be tested for the COVID-19 virus?		
Does anyone you live with or have close contact with work where a positive case of COVID-19 has been identified?		

Do you have any of these symptoms?

- Cough Yes _____ No _____
- Shortness of breath Yes _____ No _____
- Fever Yes _____ No _____
- Chills Yes _____ No _____
- Sore throat Yes _____ No _____
- Muscle Pain Yes _____ No _____
- Loss of Taste or Smell Yes _____ No _____

Temp _____
Any temp above 99.4 NO VISIT.

I declare that the information provided above is true and correct to the best of my knowledge.

Signature _____ Time _____

For any YES answer, Visitation is NOT PERMITTED.

PLEASE ALSO NOTIFY ED, ADMINISTRATOR, DNS FOR ADMINISTRATIVE FOLLOW UP.