Burwell Community Memorial Health Center

Nurse Name:_____

Nurse Initial: _____Time: _____

COVID-19 Health Questionnaire

Have you been in contact with anyone with COVID19?

☐ Yes ☐ No

If yes:

When & how long? _____

Were you masked? _____

Visitor Temperature: _____

Visitor has Mask: _____

Visitor washed hands: _____

Where you in contact with anyone exhibiting symptoms of illness?

☐ Yes ☐ No

Have you experienced any of the following **NEW** symptoms in the past 48 hours:

- ☐ Cough
- ☐ Shortness of Breath or difficulty breathing
- ☐ Fever
- ☐ Chills
- ☐ Muscle Pain
- ☐ Sore Throat
- ☐ New Loss of Taste or smell
- ☐ Runny Nose
- ☐ Diarrhea, nausea, vomiting
- ☐ Chest pains
- ☐ Sore Throat
- ☐ Generalized weakness
- ☐ Unusual Rashes rash over toes
- ☐ Confusion
- ☐ Congestion
- ☐ **NONE OF THE ABOVE**

Have you developed a fever within the last 14days of a visit? ☐ *YES* ☐ *NO*

If yes, the visitor must leave and set up another scheduled time to visit with their loved one when not symptomatic.

I have been educated and understand the visiting rules and the importance of handwashing.

Date:_____

Your Name:_____ Resident Name: _____

Signature:_____