St. Augustine Health Campus Visitor Screening Form

Visitor Name:________________________________Date and Time of Visit:__________, 2020 ______________a.m./p.m.

Address:____City:______________________State:______Zip: ___________

Phone Number:_______________Email:________________________________Resident Visiting:__________________________

To be filled out by St. Augustine Staff upon arrival:

Have you had a positive COVID-19 test? Yes No If yes, what was the date of the positive test? __________________

Have you had any of the following symptoms in the past 72 hours?

Fever (≥100.4F)	Nausea or Diarrhea	Chills/Shaking with Chills
Cough	Muscle Aches or Pains	Sore Throat
Shortness of Breath	New Loss of Taste or Smell	Headache
Fatigue	Congestion or Runny Nose	

Have you been exposed to anyone with a positive COVID-19 test or any of these symptoms? Yes No

If yes, document date of exposure and circumstances: ____

Visitor's Temperature:________________________ F

Acknowledgment

By my signature below, I certify that my responses to the questions above are true and accurate to the best of my knowledge. I understand that if any of the responses are knowingly false when made that my visitation privileges will be revoked. I express my understanding and agreement to do the following, as conditions of visitation:

- I understand I must wear a face mask at all times during my visit. If visiting a resident that is bed-bound, I understand I must wear a face mask, gown and gloves at all times during my visit.
- I understand that I must remain at least six feet away from the resident during visitation.
- I understand I may not hug, kiss, shake hands with, or touch the resident during visitation.
- I understand I must clean my hands with alcohol-based hand rub or by handwashing before and after my visit. I understand I may not eat or drink during my visit.
- I understand that if I develop any of the above-identified symptoms of COVID-19 within 72 hours of my visit I must notify the facility immediately.
- I understand that if I am notified I was exposed to a person prior to my visit that tested positive for COVID-19 I must notify the facility immediately.
- I understand that I will be escorted to the visitation area, I must remain in the visitation area, and I may not enter any part of the facility.
- I understand that the visitation will be monitored in order to observe adherence to these conditions.
- I understand that if I fail to abide by any of these conditions of visitation the privilege of visitation will be revoked.

____ ______________________

Signature of Visitor Date

Effective July 20, 2020

Screener Initials: ________