RITE OF PASSAGE
IMPROVING THE LIVES OF YOUTH

COVID-19 Visitor Screening Tool

Visitor's Name: ______________________________ ***Date:*** ________________

Reason for Visit: ____

Please answer the following questions prior to entering the facility.

	YES	NO
Have you had a fever greater than 100º F within the past 14 days?	☐	☐
Have you had a cough or shortness of breath within the past 14 days?	☐	☐
Have you had nausea, vomiting or diarrhea within the past 14 days?	☐	☐
Have you had chills, body aches, headache, fatigue, or loss of taste or smell within the last 14 days?	☐	☐
Have you had pneumonia or the flu within the past 14 days?	☐	☐
Have you had direct contact (inside of 6ft for 15 minutes or more) with anyone who has lab confirmed Coronavirus within 14 days of symptom onset?	☐	☐
Have you traveled to any other States within the past 14 days? If yes, where: ______________________________	☐	☐

If you answer "yes" to any of the questions above, you must first speak to the on-duty supervisor before entering the facility.

FOR WEEKLY USE: If There Are No Changes to Your Initial Responses Above AND Your Temperature Upon Arrival Is Verified to be Below 100º F, Please Initial Daily.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Date:________ Temp: _______	Date:________ Temp: _______	Date:________ Temp: _______	Date:_______ Temp: _______	Date:_______ Temp: _______	Date:_______ Temp: _______	Date:_______ Temp: _______
*Visitor*______ *ROP*_______	*Visitor*______ *ROP*_______	*Visitor*______ *ROP*_______	*Visitor*______ *ROP*_______	*Visitor*______ *ROP*_______	*Visitor*______ *ROP*_______	*Visitor*______ *ROP*_______

Your signature below indicates you have answered the questions to the best of your knowledge.

Visitor Signature: ______________________________ ***Date:*** ________________