

## VISITOR COVID-19 SCREENING FORM

\*Name: \_\_\_\_\_ \*Telephone #: \_\_\_\_\_

Court/Office Visiting: \_\_\_\_\_

Date: \_\_\_\_\_ Time In: \_\_\_\_\_ Temperature: \_\_\_\_\_

### **In the past 24 hours, have you experienced any of the following symptoms?**

- |  |          |         |
|--|----------|---------|
| ➤ Cough  | Yes ____ | No ____ |
| ➤ Shortness of breath or difficulty breathing        | Yes ____ | No ____ |
| ➤ Fever of 100 degrees F or 37.8 degrees C, or above | Yes ____ | No ____ |
| ➤ Chills   | Yes ____ | No ____ |
| ➤ Sore Throat  | Yes ____ | No ____ |
| ➤ Headache   | Yes ____ | No ____ |
| ➤ New or Loss of Taste or Smell                      | Yes ____ | No ____ |
| ➤ Fatigue  | Yes ____ | No ____ |
| ➤ Muscle or body aches                               | Yes ____ | No ____ |
| ➤ Nausea or vomiting                                 | Yes ____ | No ____ |
| ➤ Diarrhea   | Yes ____ | No ____ |

### **In the past 14 days have you:**

- |   |          |         |
|---|----------|---------|
| ✓ Had close contact (within 6 feet for a prolonged period of time) with someone with a diagnosis of COVID-19? | Yes ____ | No ____ |
| ✓ Traveled internationally or domestically (out-of-state)?  | Yes ____ | No ____ |

---

### **Security Officer:**

If visitor answered "yes" to any of the above, visitor is not permitted access to the premises. Contact the department with which the individual must do business so as to provide service at the door.

Contacted Court/County Office and informed them the visitor requires service at the door.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Spoke to: \_\_\_\_\_

\*This information will not be utilized or distributed for any purpose other than Contact Tracing, i.e. to investigate contacts should you later experience symptoms of Covid-19 or be determined to have had contact with another individual who subsequently displays symptoms. The information is held in a secure area for not longer than 30 days.