COVID-19 VISITOR HEALTH CHECK LOG

*ALL INFORMATION BELOW SHOULD BE TREATED AS PRIVATE HEALTH INFORMATION AND RECORDED, SHARED, AND RETAINED ACCORDING TO ADA, HIPAA AND LOCAL PRIVACY LAWS.

DATE: _____ BUILDING/ LOCATION: _____

Visitor Name (First and Last)	Company/ Phone #	Temperature Check (F°/C°)	Cough/ chest congestion	Sore throat/ loss of taste	New Shortness of Breath	Runny nose/ congestion/ loss of smell	Fatigue/ headache/ body aches	Vomiting/ diarrhea	Fever-reduce meds w/in 14 days?	DENIED ACCESS?
			Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
			Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

*If granted access, ask visitor to contact _____ if they experience COVID-19 symptoms or test positive for COVID-19 within 14 days of their visit; or if they discover they had close contact with someone diagnosed or suspected of COVID-19 up to 48 hours before they visited.

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