cedarhurst SENIOR LIVING

Coronavirus (COVID-19) APPROVED MEDICAL PERSONNEL Signs & Symptoms Screening

All persons 15 yrs. or under are RESTRICTED from entering the Community.

Name: _____ Date: _____

Best Contact Number: (_____)_____ Agency Name: _____

Resident(s) you plan to have close contact with? _____

_____

1) Did you or someone you are in close contact with had congregate travel (i.e. airplane, train, cruise boat, etc.) in the last 14 days? ☐ YES ☐ NO

If YES, you are restricted from entering for a minimum of 14 days after you or your close contact returned and are confirmed as not having any signs or symptoms of the Coronavirus (COVID-19) for at least 72 hours.

2) Have you or someone you are in close contact with tested positive for the Coronavirus in the last 14 days? ☐ YES ☐ NO

If YES, you are restricted from entering for a minimum of 14 days after you or your close contact are no longer positive for the Coronavirus (COVID-19) and are free from any signs or symptoms of the Coronavirus (COVID-19) for at least 72 hours.

3) Are you experiencing any of the following symptoms:

a. Fever (*current temperature is:* _____) ☐ YES ☐ NO
   **fever is considered 99.5 degrees or above*
   Also, please list any medications taken within the last 24 hours that may lower your temperature (Tylenol, NSAIDs, Aspirin or any cold medications):
   _____
b. Sore throat ☐ YES ☐ NO
c. Cough ☐ YES ☐ NO
d. Shortness of breath ☐ YES ☐ NO

If yes to any, you are restricted from entering until receiving a thorough clinical evaluation (noted on reverse page) or you are confirmed as no longer having any signs or symptoms of the Coronavirus (COVID-19) for at least 72 hours.

MUST Complete Reverse Side

4) Please list all healthcare facilities, including hospitals, emergency rooms, long-term care facilities, senior living communities, outpatient treatment facilities, hospices and home health agencies, that you and those you are in close contact with have worked in/for or visited the last 14 days:

_____
_____

5) Please note any other special circumstances or considerations:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Agreement of Understanding

By signing below, I hereby certify that:

- All my answers and statements in this Signs & Symptoms Screening & Acknowledgement are true to the best of my knowledge and belief; and
- Failure to follow **proper infection control procedures**, including **handwashing and cough etiquette**, may **restrict** me from further entry into the Community.

_____ Date: _____
Medical Personnel Signature

_____ Date: _____
Medical Personnel Printed Name

_____ Date: _____
Cedarhurst Screener Signature

_____ Date: _____
Cedarhurst Screener Printed Name