cedarhurst
SENIOR LIVING

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

All persons 15 years 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 have congregate travel (i.e. airplane, train, cruise boat, etc.) in the last 14 days? ☐ YES ☐ NO

If YES, you are restricted from entering until a negative COVID-19 test result can be obtained after returning for a minimum of 7 days, or 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 COVID-19 in the last 14 days? ☐ YES ☐ NO

If YES, you are restricted from entering until a negative COVID-19 test result can be obtained after 7 days of exposure, or 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 COVID-19 for at least 72 hours.

3) 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:

_____

_____

_____

_____

4) Do any of healthcare facilities you listed above have active COVID-19 tested positive for the Coronavirus in the last 14 days? ☐ YES ☐ NO

If YES, you are restricted from entering until a negative COVID-19 test result can be obtained after 7 days of potential exposure or a minimum of 14 days after your last visit from the healthcare facility and are free from any signs or symptoms of the Coronavirus (COVID-19) for at least 72 hours.

MUST Complete Reverse Side

5) Are you experiencing any of the following symptoms:

a.	Cough	☐ YES	☐ NO
b.	Shortness of breath or difficulty breathing	☐ YES	☐ NO
c.	Fever or chills (*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):		
	_____		
d.	Fatigue	☐ YES	☐ NO
e.	Muscle or body aches	☐ YES	☐ NO
f.	Headache	☐ YES	☐ NO
g.	Sore throat	☐ YES	☐ NO
h.	Congestion or runny nose	☐ YES	☐ NO
i.	Nausea or vomiting	☐ YES	☐ NO
j.	New loss of taste or smell	☐ YES	☐ NO

If YES to any, you are restricted from entering until a negative COVID-19 test result can be obtained, or for a minimum of 14 days and you are free from any signs or symptoms of the Coronavirus (COVID-19) for at least 72 hours.

6) 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