COVID-19 Health Screening Visitor Log

Date

Visitor Name

Phone Number

Organization / Company

Person Visiting / Purpose

Time In

Time Out

Do you have any of the following symptoms: fever, cough, difficulty breathing, sore throat, or loss of taste/smell?

Yes No

Have you had close contact with a confirmed COVID-19 case in the past 14 days?

Yes No

Have you traveled internationally or been in a COVID-19 outbreak area in the last 14 days?

Yes No

Visitor Signature

Staff Initials