

Terrace View Employee/Visitor/ Contractor Screening Form

Updated September 21, 2020

The difference between healthcare and true care™



Date: _____ Time: _____

Employee/Visitor/Contractor Name: _____

Visitor: Street Address _____

Visitor: Day Phone # _____ Evening Phone # _____

Visitor Email Address: _____

Visitor Verification of NEGATIVE COVID Swab: Text _____ Hard Copy _____ Email _____

Department/Company _____

IF YOU ARE EXPERIENCING ANY OF THE SIGNS/SYMPTOMS

Temp \geq 100.0 F..... _____

New onset/change in cough..... YES NO

New onset/change in Shortness of Breath..... YES NO

New onset/change in Congestion/Runny Nose YES NO

New onset of Muscle Pain..... YES NO

New onset of Chills YES NO

New onset of Shaking with Chills YES NO

New onset/change in Headache..... YES NO

New onset /change of Sore Throat..... YES NO

New onset of loss of taste and/or smell YES NO

New onset Nausea/Diarrhea YES NO

Have you tested + for COVID in the last 14 days YES NO

Have you been in close contact with a confirmed
or suspected person with Covid?.....YES NO

Have you traveled outside NYS to any
Increased Infection Rate State? Indicate State _____ YES NO

** if YES regarding travel, please notify Valerie Killion 898-4906*

give name, department/location, where traveled.

Employee needs to be sent home YES or NO Supervision Notified _____

Screener Initials _____