Terrace View Employee/Visitor/ Contractor Screening Form

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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 >/= 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 _____