IIC VISITOR SIGN IN

Date _____ **Name** _____

Address _____

Email _____

Phone Number_____

Purpose for visit _____

COVID-19 Screening Questionnaire

- Have you tested positive for COVID-19 in the last 14 days? ☐**YES** ☐ **NO**
- Have you been tested for COVID-19 symptoms and are still waiting for results? ☐**YES** ☐ **NO**
- Have you or anyone in your household experienced any of the following symptoms in the past 48 hours?
  Fever (greater than 100.4 F), chills, cough, shortness of breath, loss of taste or smell, nausea or vomiting, diarrhea, sore throat, headache, muscle or body aches or fatigue? ☐**YES** ☐ **NO**
- Within the past 10 days, have you been in close physical contact (6ft or closer for a cumulative period of 15 minutes) with someone who is known to have tested positive for COVID-19, or anyone who has shown symptoms consistent with COVID-19? ☐**YES** ☐ **NO**
- Is anyone in your household currently awaiting results of a COVID-19 test? ☐**YES** ☐ **NO**
- Has anyone in your household tested positive for COVID-19 in the past 10 days? ☐**YES** ☐ **NO**
- Have you traveled out of the state of California in the last 10 days? ☐**YES** ☐ **NO**

Signature _____

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