SPRINGBROOK

COVID-19 Visit Questionnaire for Friends and Family

Parent/Visitor Name

Resident Name

Cell Phone

Date of Visit

Date

Time of Visit

Hour Minutes

Where do you currently reside?

City

State

Did you travel in the last 14 days?

- No
- Yes

PCR Testing Details

Have you ever tested "Positive" for COVID-19?

- No
- Yes

Have you or anyone in the household had:

Any Suspected or Confirmed COVID-19 Exposures in the past 14 days?

- No
- Yes

Any Positive test results or pending test results related to COVID-19?

- No
- Yes

Any of the following symptoms in the last 14 days? ☐ No ☐ Yes

1. Temperature of 100 or higher?
2. Shortness of breath
3. Cough
4. Sore Throat
5. Flu-like Symptoms
6. Gastrointestinal symptoms (N,V, or D)
7. Conjunctivitis
8. Change in taste or smell (may be a decrease appetite for person with ID/DD)
    1. If So, List: ______________
9. Additional Notes ______________