

## Visitor Health Screening Form

Visitor Name: \_\_\_\_\_ Date Filled Out: \_\_\_\_\_

Inmate Visiting: \_\_\_\_\_ JID Number: \_\_\_\_\_

Please circle Yes or No for the questions below:

1. Today, or in the last 24 hours, have you had any of the following symptoms: fever or chills, cough, difficulty breathing, loss of appetite, diarrhea, lost sense of taste or smell, sore throat?

Yes                  No

2. In the past 14 days, have you had contact with a person confirmed or suspected to be infected with the novel coronavirus (COVID-19)?

Yes                  No

3. Are you compliant with COVID-19 travel advisories in place at the time of this visit, including travel to New York from another State?

Yes                  No

4. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?

Yes                  No

**Do not write below this line – WCDOC Staff ONLY**

Officer Name and Shield Number: \_\_\_\_\_ Date: \_\_\_\_\_

Did visitor answer YES to any of the above questions?                  Yes                  No

Did visitor have a temperature of 100.4°F or above?                  Yes                  No

Visitor Allowed Entry: \_\_\_\_\_ Visitor Denied Entry: \_\_\_\_\_