

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 10 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 10 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: _____