Sandy Creek COVID-19 Visitor Screening Form

Your Name____

Please circle yes or no.

Have you traveled outside of the USA in the last 10 days?	No	Yes
Have you traveled outside of NYS in the last 10 days?	No	Yes
Have you been on a cruise ship in the last 10 days?	No	Yes
Have you attended any events or gatherings with more than 10 people?	No	Yes
Have you tested positive for COVID-19?	No	Yes
Have you been in close contact with anyone who has tested positive for COVID-19?	No	Yes
Have you been asked to self-quarantine?	No	Yes

Are you currently experiencing or have you experienced any of the following symptoms?

Fever or Chills	No	Yes
New Loss of Taste/sense of smell	No	Yes
Sore throat	No	Yes
Diarrhea	No	Yes
Headache	No	Yes
Cough	No	Yes
Shortness of Breath or Difficulty Breathing	No	Yes
Muscle/Body Aches	No	Yes
Fatigue	No	Yes
Nausea/Vomiting	No	Yes
Congestion/Runny Nose	No	Yes