KENDAL® at Oberlin
Together, transforming the experience of aging.®

TIME
_____ ARRIVED

_____DEPARTED

_____ RM Sanitized

Family/Friends SCC Visit Screening Tool

VISITORS Name: _____

Name of Resident being visited_____

Resident requests "touch" during visit YES / NO

Date of Screening: _____

Negative COVID TEST
YES/NO
DATE_____

COVID VACCINE
YES – Fully / NO
DATE_____

Have you traveled by plane or cruise ship within and/or outside the United States in the last 14 days?	If YES, please indicate details:			
Fever (>99.6°F) or history of fever within the last 14 days?	Please indicate temperature and/or history details:		**CURRENT TEMP**	
Symptoms:	YES	YES	NO	NO
	Visitor	Tester	Visitor	Tester
Sore throat				
Cough, Congestion, Runny Nose				
Headache				
Shortness of breath/difficult breathing				
Diarrhea, Nausea, Vomiting				
Chills				
Muscle or Body aches				
New loss of taste or smell				
Exposure to individuals with covid-19 within the last 14 days?				
Education Provided:	□ Printed Material provided			
	□ Hand hygiene, Used Hand sanitizer			

Reviewer _____ Date _____

The above signs/symptoms have been reviewed with me. I have also been instructed and understand to immediately report any of the above symptoms to the nurse.