ST. JOHNLAND
NURSING CENTER

Temperature: _____

Coronavirus Disease (COVID-19) – Family Visitor Screening

Visitor Name: _____ Date: _____ Time: _____

Resident Name: _____ E-Mail: _____

Day Phone: _____ Evening Phone: _____

Address: _____ City: _____ St: _____

Anticipating the need to protect against coronavirus risk, St. Johnland Nursing Center has implemented additional measures to safeguard the health of residents, employees and families, as well as visitors to the center.

1. Have you traveled from affected geographic areas within the last 2 weeks?
   _____ NO _____ YES If yes, the Date you left _____

2. Have you had close contact in the past 2 weeks with a confirmed COVID-19 person?
   _____ NO _____ YES If yes, the Date you had contact _____

3. Do you have any of the following symptoms?

____ Fever	____ Shortness of Breath	____ Cough
____ Runny Nose	____ Nasal Congestion	____ Sore Throat
____ Nausea	____ Vomiting	____ Diarrhea

_____ Signature

_____ Screener Signature