

Emergency Department Visitor Form

Name of visitor:

Phone number:

Patient name:

Date/time:

Code word:

Clinical signs and symptoms/exposure risks

1 or more checks, visitor is not permitted

(Exceptions approved by charge nurse)

- ☐ Currently has a fever greater than 100°F **Screening Temperature** _____
- ☐ Has had fever greater than 100°F last 24 hours, or has medicated to treat a fever over 100°F in the last 4 hours
- ☐ Persistent chest pain or pressure, in conjunction with another symptom listed below
- ☐ Cough or shortness of breath, new or worsening within the last 7 days
- ☐ Fatigue, myalgias, altered level of consciousness, new onset with the last 7 days
- ☐ Sore throat, runny nose/nasal congestion, headache, new loss of taste/smell
- ☐ Nausea, vomiting or diarrhea; chills, or repeated shaking
- ☐ Awaiting confirmation of a COVID-19 laboratory result
- ☐ Has tested COVID-19 positive and does not have a letter of release from health department OR has new symptoms
- ☐ In the past 14 days, has been closer than 6 feet for more than 15 minutes to a person confirmed to have COVID-19 and at least one person was not masked

Staff Name _____

Date/Time _____

Print Name

