Coronavirus (COVID-19)
Signs and Symptoms Screening

Name: _____ Date: _____
Contact Number: _____
If Guest: Name of resident(s) visiting? _____

1. Have you or someone you are in close contact with travelled outside the US in the last 30 days? ☐ Yes ☐ No
   If YES, please refrain from visiting for a minimum of 14 days after you or your close contact has returned to the U.S. and are confirmed as not having any signs or symptoms of the Coronavirus (COVID-19), cold or flu like symptoms for at least 72 hours.

2. Have you or someone you are in close contact with tested positive for the Coronavirus in the last 30 days? ☐ Yes ☐ No
   If YES, please refrain from visiting for a minimum of 14 days after you or your close contact are no longer positive for the Coronavirus (COVID-19) and are free from any signs or symptoms of the Coronavirus (COVID-19), cold or flu like symptoms for at least 72 hours.

3. If NO to #1 and #2, are you experiencing any of the following symptoms:
   a. Fever (Current Temp: _____) ☐ Yes ☐ No (*99.5° F or above = FEVER)
   b. Sore throat: ☐ Yes ☐ No
   c. Cough: ☐ Yes ☐ No
   d. Shortness of breath: ☐ Yes ☐ No

If yes to any of #3 questions, please refrain from visiting/working until receiving a thorough clinical evaluation (please note below) or you are confirmed as no longer having any signs or symptoms of the Coronavirus (COVID-19), cold or flu like symptoms for at least 72 hours.

NOTES: _____
_____
_____
_____

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715 Shadybrook Dr NE | Marietta, GA 30066 | (678) 656-5255
www.southerncomfortseniorliving.com