

## Parkwood Heights Visitor Covid-19 Screening Questions

1. Have you knowingly been in close or proximate contact in the past 14 days with anyone who has tested positive for COVID-19 or who has had symptoms of COVID-19?  Yes  No
2. Have you tested positive for COVID-19 in the past 14 days?  Yes  No
3. Have you experienced any symptoms of COVID-19 in the past 14 days?  Yes  No
4. In the last 14 days, have you traveled from another state or country for which New York State requires a mandated self-quarantine period?  Yes  No
5. If you answered "Yes" to question 4, have you completed the 14 day self-quarantine as currently required by New York State?  Yes  No

Temperature Check Completed: \_\_\_\_\_ (Staff Initial)

Visitor Name: \_\_\_\_\_

Visitor Address: \_\_\_\_\_

Visitor Daytime Phone: \_\_\_\_\_

Visitor Evening Phone: \_\_\_\_\_

Visitor Email: \_\_\_\_\_

Date of Visit: \_\_\_\_\_

Start Time: \_\_\_\_\_ End Time: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Resident name you are visiting and Apartment #

**For Staff Use Only: Screening PASS or FAIL (Circle One)**