# VISITOR HEALTH SELF-ASSESSMENT FORM

*In an effort to reduce the risk of COVID-19 exposure to Yates County employees, all visitors must complete the following self-assessment. If you answer "yes" to any questions you shall not be allowed access to Yates County Buildings:*

Date: _____ Time: _____

Visitor's name (*please print*): _____

_____

*(If more than one person from the same household is with you, include everyone's name)*

Person/department visiting: _____ Visitor's phone number: _____

## HAVE YOU:

1. Traveled outside of New York State within the last 14 days? If "yes", where did you visit? _____
   *(Name of the State you visited if stay was longer than 12 hours)*
2. Had close contact with or cared for someone diagnosed with COVID-19 within the last 14 days?
3. Tested positive for COVID-19 in the last 14 days?
4. Experienced any cold or flu-like symptoms in the last 14 days?
   A. Cough
   B. Fever or chills
   C. Shortness of breath or difficulty breathing
   D. Fatigue
   E. Muscle or body aches
   F. Headache
   G. New loss of taste or smell
   H. Sore throat
   I. Congestion or runny nose
   J. Gastrointestinal issues (i.e. vomiting, etc.)

**Check the appropriate box:**

☐ **YES** ☐ **NO**

Visitor signature: _____

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**FOR INTERNAL USE ONLY**

Access to facility ***approved*** unless specified otherwise. *Denied:* _____
*(Reason)*

Employee Initials (*Circle One*): AG GC JS KB KV NJ SI *Other:* _____