LUTHERAN CARE CENTER
VISITOR INFORMATION

FULL NAME: _____

ADDRESS: _____

_____

DAYTIME PHONE: _____

EVENING PHONE: _____

EMAIL ADDRESS: _____

VISIT DATE: _____

VISIT TIME: _____

(COMPLETE "TIME" UPON ARRIVAL TO LCC)

SIGNATURE: _____

Please answer the following questions:

1. Do you have symptoms of a respirator infection; fever, shortness of breath, cough, or sore throat? Yes or No

2. Have you had contact with someone with or under investigation for COVID-19 in the past 14 days? Yes or No

3. Have you visited any of the high risk states under Commissioner Advisory in the past 14 days? Yes or No

4. Have you provided documentation of a negative COVID-19 result in the last 7 days? Yes or No

Temperature: _____ **(Done by LCC staff upon arrival)**