LUTHERAN CARE CENTER
Visitor Screening Form
(Contact Tracing Information, if needed)

FULL NAME: _____

ADDRESS: _____

_____

DAYTIME PHONE: _____

EVENING PHONE: _____

EMAIL ADDRESS: _____

VISIT DATE: _____

VISIT TIME: _____

(**COMPLETE "TIME" UPON ARRIVAL TO LCC)**

Visitor Signature: _____

Please answer the following questions:

Do you have symptoms of a respirator infection: fever, shortness of breath, cough, or sore throat? **Yes** **No**

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

Have you traveled in the past 14 days? **Yes** **No**

Have you received a COVID-19 vaccine? **Yes** **No**

For Staff Completion

Temperature: _____

Rapid Test Result: _____

Staff Signature/Title: _____

Updated: Feb--2021