GRAND TRAVERSE PAVILIONS
Grand Traverse Medical Care

VISITOR CORONAVIRUS SCREENING FORM

Name: ____

Date/Time: ___________________________

Part I: Questionnaire		
Please answer the following:	**Yes**	**No**
Have you traveled the past 14 days outside of Michigan?		
Do you have a fever? (Record temperature here: ______)		
Do you have a cough, shortness of breath, or difficult breathing?		
Are you experiencing chills or repeated shaking with chills?		
Are you experiencing a sore throat, muscle pain or headache?		
Are you experiencing new loss of taste or smell?		
In the past 14 days, have you had contact with someone with/suspected to have COVID-19, or is ill with respiratory illness?		

Part II: Comments

Provide additional information, if you answered yes to any of the above.

Part III: Action/Signature

Visitation denied: ______ No ______ Yes (exhibits symptoms)

1. Visitor understands to contact Grand Traverse Pavilions should they develop any signs or symptoms of COVID-19 within 14 days after their visit. ______ Yes ______ No
2. Visitor understands that the use of PPE while at Grand Traverse Pavilions is required. ______ Yes ______ No
3. Visitor understands that Grand Traverse Pavilions will contact them if potential exposure to COVID-19 is suspected based on contact tracing. ______ Yes ______ No

Visitor Signature: ____________________________________ Date: ____________________

Visitor phone number and email address:

____

Screener Signature: __________________________________ Date: ____________________