CALIFORNIA DEPARTMENT OF
Mental Health

Atascadero State Hospital
P. O. Box 7001, Atascadero, CA 93423-7001
(805) 468-2000 • FAX: (805) 466-6011

September 29, 2009

Dear Visitor:

To help ensure the health and safety for both our individuals and staff, we ask that you complete the following questionnaire to indicate if you currently have any of the following conditions.

1. Active fever or fever in the last 7 days — Yes ____ No ____
2. Active cough — Yes ____ No ____
3. Shaking chills — Yes ____ No ____
4. Sore throat with or without swollen glands in your neck — Yes ____ No ____
5. Unusual or severe headache or neck pain — Yes ____ No ____
6. Active vomiting or diarrhea is the last 48 hours — Yes ____ No ____
7. In the last month, have you been around a person who has had measles, mumps, or chickenpox, and you have never had them nor been vaccinated against them? — Yes ____ No ____

If you have any of the above conditions, we encourage you to seek medical attention with your medical practitioner as soon as possible.

_____ _____ _____
Print Name Signature Date

Once you have recovered, you may reschedule your visit.

Thank you for your cooperation.

JON DE MORALES
Executive Director