DEPARTMENT OF STATE HOSPITALS - ATASCADERO
PO Box 7001
Atascadero, CA 93423-7001
805-468-2001

December 9, 2014

Dear Visitor:

To help ensure the health and safety for both our patients 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 ____
8. Have you had a flu vaccination for the 2014-2015 flu season? 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.

LINDA S. PERSONS
Executive Director