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