Arc Jefferson-St. Lawrence
New York

HOME VISIT QUESTIONNAIRE

PWS Name:_____ Dates of Visit:_____

Address of Visit:_____

Prior to home visit:

PWS Health Screening:

Symptom Check Negative? YES NO Temp Below 100.0 Degrees? YES NO

1. Is anyone in the household currently under isolation or quarantine for COVID-19? YES NO
2. Has anyone in the household had any known exposure to COVID-19 in the last 14 days? YES NO
3. Has anyone in the household had any of the following symptoms in the last 14 days? YES NO
    a. Cough
    b. Fever of 100.0 degrees or greater
    c. Sore Throat
    d. Shortness of breath
    e. Headache
    f. Chills
    g. Muscle Pain
    h. New loss of taste or smell

Addresses of any and all places the individual spent time during the home visit, including the names of other people spending time in close contact (within 6 feet) or proximate contact:_____

_____

_____

_____

_____

_____

_____

Arrival back to site from home visit:

PWS Health Screening:

Symptom Check Negative? YES NO Temp Below 100.0 Degrees? YES NO

_____ _____
Staff Signature/Title Date

_____ _____
Signature of Person Picking Up Date

_____ _____
Signature of Person Dropping Off Date