



Assisted Living Center ~ Salisbury

"A Community Built on a Lifetime of Experiences"

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Covid19 Coronavirus Screening Questions

Have you in the past 14 days

- | | | |
|---|-----|----|
| 1. traveled in China, Iran or Italy? | Yes | No |
| 2. traveled internationally? | Yes | No |
| 3. had close face to face contact (within 6 feet)
with someone who would answer yes
to any of the previous questions? | Yes | No |

Do you have

- | | | |
|--|-----|----|
| 4. a cough? | Yes | No |
| 5. shortness of breath/breathing difficulties? | Yes | No |
| 6. muscle aches, fatigue, headache? | Yes | No |
| 7. sore throat, runny nose, diarrhea? | Yes | No |
| 8. a fever? | Yes | No |

What is your temperature today? _____

**If YES to any of these questions or if your
temperature is 100.3 or over,
you must leave immediately.
Contact your primary care physician.**

Staff Name: _____

Person Verifying: _____

Date: _____