

Kent Institute // COVID-19 Pre-visit Form

Please complete this pre-visit form in full. ALL fields are required and incomplete forms may cause a delay in approval.

First Name

Last Name

E-mail address

Date

Have you had any of the following symptoms within the last 24 hours, which is not new or not explained by other reasons? Please check all that apply.

Symptoms:

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Repeated shaking with chills |
| <input type="checkbox"/> Headache | <input type="checkbox"/> New loss of taste or smell |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Runny or congested nose |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Feeling unusually weak or fatigued |
| <input type="checkbox"/> Muscle pain | |

Have you worked in facilities or locations with recognized COVID-19 cases?

YES

NO

If YES, did you work with anyone with confirmed COVID-19 cases?

YES

NO

Have you had close contact within someone who in the last 14 days has been in isolation for COVID-19 or had a test confirming they had the virus?

YES

NO

Have you recently had a COVID-19 test and are currently awaiting the results?

YES

NO

Answering YES to any of the above questions will in no way preclude you from visiting Kent Institute at some point, it simply helps us to maintain a safe environment for everyone concerned.