CCSD
CLARK COUNTY
SCHOOL DISTRICT

Department Name:

VISITOR QUESTIONNAIRE AND ACKNOWLEDGEMENT

First Name	Last Name	Cell Phone	Email

In accordance with the Southern Nevada Health District (SNHD) Guidelines, if you answer yes to any of the following questions, you shall not be permitted entry to the facility. Circle the respective answer to each question.

1. Do you have a new or worsening cough that cannot be attributed to another health condition?	YES	NO
2. Do you have new or worsening shortness of breath that cannot be attributed to another health condition?	YES	NO
3. Do you have a **fever (100.4° F or higher) or new loss of taste or smell**	YES	NO
4. Do you have any two or more of the following symptoms: **new or worsening headache, sore throat, chills, repeated shaking with chills, muscle pain, vomiting, diarrhea, new congestion/runny nose or excessive fatigue?**	YES	NO
5. Have you come into close contact (within 6 feet for 15 minutes or more in a 24-hour period) with someone who has a laboratory-confirmed COVID-19 diagnosis in the past 10 days?	YES	NO
6. Have **you** received a laboratory-confirmed positive COVID-19 diagnosis in the last 10 days?	YES	NO

I acknowledge that being on a CCSD campus is for my personal benefit and that I will immediately be asked to leave and will be given instructions for rescheduling my visit if I become ill. In addition, if I become symptomatic and/or receive a positive COVID-19 test result within ten (10) days of my visit to the CCSD building, I will immediately contact them at 702-799-_____ and give my name and the date of my visit and who I met with to notify the SNHD to make appropriate contact notifications during this pandemic.

_____ Signature

_____ Date

For Office Use Only

Appointment Date:	Building/Room	Name of Employee Handling Appointment