CCSD
CLARK COUNTY
SCHOOL DISTRICT

David M. Cox Elementary School

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 facility. Circle the respective answer to each question.

1. Do you have a new cough that cannot be attributed to another health condition?	YES	NO
2. Do you have new shortness of breath that cannot be attributed to another health condition?	YES	NO
3. Do you have any two of the following symptoms: **fever (100.4º F or higher), chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell**?	YES	NO
4. Have you come into close contact (within 6 feet) with someone who has a laboratory-confirmed COVID-19 diagnosis in the past 14 days?	YES	NO
5. Have you received a laboratory-confirmed positive COVID-19 diagnosis in the last 14 days?	YES	NO

I acknowledge that *(reason for being in school)*_____ 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 fourteen (14) days of my visit to the CCSD building, I will immediately contact them at 702-799-5730 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