



C A L I F O R N I A D E P A R T M E N T O F

Mental Health

Atascadero State Hospital
P. O. Box 7001, Atascadero, CA 93423-7001
(805) 466-2000 • FAX: (805) 466-6011

May 1, 2009

Dear Visitor:

To help ensure the health and safety for both our individuals and staff, we ask that you complete the following questionnaire to indicate if you currently have any of the following conditions.

- | | | |
|--|-----------|----------|
| 1. Fever | Yes _____ | No _____ |
| 2. Active cough | Yes _____ | No _____ |
| 3. Shaking chills | Yes _____ | No _____ |
| 4. Sore throat with or without swollen glands in your neck | Yes _____ | No _____ |
| 5. Unusual or severe headache or neck pain | Yes _____ | No _____ |
| 6. Loose or frequent stools (diarrhea) | Yes _____ | No _____ |
| 7. Vomiting | Yes _____ | No _____ |

If you have any of the above conditions, we encourage you to seek medical attention with your medical practitioner as soon as possible.

Print Name

Signature

Date

Once you have recovered, you may reschedule your visit.

Thank you for your cooperation.

JON DE MORALES
Executive Director