



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

Mental Health

Patton State Hospital

3102 East Highland Avenue, Patton, CA 92369
(909) 425-7321

May 4, 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.

OCTAVIO C. LUNA
Executive Director