Symptom Checker

Name: ________________________________ Date: ____________________

Affiliation:   Faculty/Staff   Student   Guest

Please check the appropriate box below.

1. Have you had any known close contact with a person confirmed or suspected to have COVID-19 in the past 14 days?
   Yes      No

2. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?
   Yes      No

3. Have you traveled within a state with significant community spread of COVID-19 for longer than 24 hours within the past 14 days?
   Yes      No

4. Do you have a temperature greater than or equal to 100 degrees Fahrenheit? Note: Screeners are prohibited from recording employee health data, eg: temperatures.
   Yes      No

5. Do you have any of the following SYMPTOMS (New or Worsening)? Cough, Shortness of Breath, Troubled Breathing, Fever, Chills, Muscle Pain, Headache, Sore Throat, New Loss of Taste, and/or New Loss of Smell.
   Yes      No