THE CITY UNIVERSITY OF NEW YORK
College of Staten Island

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 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

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