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 10 days?

   ☐ Yes ☐ No

2. Have you tested positive for COVID-19 through a diagnostic test in in the past 10 days?

   ☐ Yes ☐ No

3. Have you traveled internationally during the past 10 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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