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 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