COVID-19 Screening Questionnaire

Name: ____________________________________________

Email address: _______________________________________

Phone number: _______________________________________

Affiliation:  ☐ Student  ☐ Employee

1. Have you been in close contact with a person with a suspected or confirmed case of COVID-19 since the last time that you completed this questionnaire? (Note: Close contact is defined as within 6 feet for more than 15 minutes)
   ☐ Yes
   ☐ No

2. Have you tested positive for COVID-19 since the last time that you completed this questionnaire?
   ☐ Yes
   ☐ No

3. Are you experiencing a sudden, unexplained onset of any of these symptoms?
   • Fever (100.4° F or greater) or fever symptoms like alternating chills and sweating without taking any fever reducing medication
   • Cough
   • Trouble breathing, shortness of breath or severe wheezing
   • Sore throat
   • Runny nose/congestion
   • Chills or repeated shaking with chills
   • New loss of taste or smell
   • Muscle aches
   • Nausea, vomiting
   • Headache
   • Diarrhea
   ☐ Yes
   ☐ No

If you have any questions, concerns or have answered YES to any of the above questions, please contact Student Health Services at (814) 732-2743.

I certify all the information provided is shared to the best of my ability.

Signature: ______________________________________ Date: ____________________________