NAME: **DATE:**

Daily COVID -19 Screening Questionnaire

Please answer **Yes** or **No** to the following questions:

1. Have you been diagnosed with COVID-19 in the last 14 days? **YES or NO**

2. To your knowledge, have you been in close contact with someone diagnosed with COVID-19 -or- someone who has not been confirmed but has been experiencing COVID-19 symptoms in the last 14 days? **YES or NO**

3. Have you had a FEVER of 100.4F or greater -or- new onset of respiratory symptoms (for example: worsening or uncontrolled cough, shortness of breath or difficulty breathing) in the last 48 hours? **YES or NO**

4. Have you experiences body aches, chills, loss of taste or smell, nausea, diarrhea or vomiting in the last 48 hours? **YES or NO**

5. Have you or has anyone in your household traveled out of the country or to any state that has any travel restrictions in the last 10 days (or 7 days followed by a negative COVID test)? **YES or NO**

6. I ATTEST THAT I HAVE TAKEN MY TEMPERATURE TODAY AND IT IS BELOW 100.4F. **YES or NO**

IF you answer "NO" to #1-5 AND your temperature is less than 100.4F
YOU MAY COME ONTO CAMPUS.

IF you answer "YES" to any of the above or you have a temperature greater than 100.4F
PLEASE STAY HOME.