



## COVID-19 Active Screening Questionnaire

Your health and well-being are of the utmost importance and we are taking measures to keep the students, staff, and faculty safe. Therefore, anyone coming onto campus will be screened and part of our screening process will include taking their temperature and asking the following questions.

**IMPORTANT:** Contact tracing is one of the most important ways to prevent further spread of COVID-19. Please make sure the cell phone number you provide is the best number to reach you. This will be used if a contact tracer needs to reach you.

Are you a Student, Employee or Visitor? (circle one)

Student / Employee / Visitor

Name: \_\_\_\_\_

Student/Employee ID #: \_\_\_\_\_

Cell phone number: \_\_\_\_\_

Date: \_\_\_\_\_

1. Have you tested positive for COVID-19 in the past 14 days?
- a. Yes
  - b. No

If yes, when did you receive a positive test result?  
(DATE): \_\_\_\_\_

If yes, have you had any symptoms related to COVID-19?

- a. Yes
- b. No

If yes, when was the last time that you experienced symptoms relating to COVID-19?  
(DATE): \_\_\_\_\_

2. Have you had a temperature of 100.4 F or greater within the last 24 hours?
- a. Yes
  - b. No
3. Do you currently have a temperature of 100.4 F or greater **OR** do you have chills?
- a. Yes
  - b. No

4. Do you have a temperature of 100.4 F or greater **AND** at least one of the following: Cough, Shortness of Breath, Sore Throat, Fatigue, Muscle Ache, Head Ache, Loss of Taste/Smell?
- a. Yes
  - b. No

5. Have you been in close contact with someone with a lab-confirmed case of COVID-19 while wearing a mask, in the past 14 days?
- a. Yes
  - b. No

6. Have you been in close contact with someone with a lab-confirmed case of COVID-19 while **NOT** wearing a mask, in the past 14 days?
- a. Yes
  - b. No

If yes, when was the last time that you were in close contact with this individual?  
(DATE): \_\_\_\_\_

7. In the last 48 hours, have you had any of the following **NEW** symptoms:
- a. Fever of 100.4° F (37.8° C) or above
  - b. New cough (excluding seasonal allergies)
  - c. Shortness of breath
  - d. Congestion or runny nose (excluding seasonal allergies)
  - e. Chills or repeated shaking with chills
  - f. Muscle or body aches
  - g. Unexplained fatigue
  - h. Sore throat
  - i. New loss of smell or taste, or a change in taste
  - j. Nausea, vomiting or diarrhea
  - k. New Headache
  - l. None of the above