CORONAVIRUS SCREENING QUESTIONNAIRE (VISITOR)

Your safety is our priority. We are screening employees, students, and visitors for signs of virus. Please answer the questions below, provide your name and date. Thank you!

EZID Label

In the past 14 days:	YES	NO
Have you had close contact with a person KNOWN to have the novel coronavirus?	☐	☐
Have you, yourself, had the novel coronavirus?	☐	☐
Do you currently have any of the following symptoms:		
• FEVER of 100 degrees or higher?	☐	☐
• MUSCLE SORENESS OR HEADACHES, accompanied by shaking, chills and feeling feverish?	☐	☐
• New onset of COLD/FLU symptoms, running nose, sore throat along with feeling feverish?	☐	☐
• New onset of STOMACH UPSET such as abdominal pain, diarrhea, or vomiting with feeling feverish?	☐	☐
• New loss of TASTE or SMELL?	☐	☐
• CONJUNCTIVITIS ("pinkeye," or inflammation of eye including redness, itching, and tearing) with feeling feverish?	☐	☐

CONTACT ON CAMPUS:

Contact on Campus Name

Contact on Campus Phone Number

Contact on Campus Email Address

Location of Campus Visit

Print Name

Phone Number

Email Address

Date

Signature

Patient Verbalized?

YES ☐ ***NO*** ☐

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V 07-10-20