

# WELLNESS 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

	YES	NO
<ul style="list-style-type: none"> <li>In the last 10 days have you, yourself, had COVID-19?</li> <li>Are currently directed by a healthcare provider or public health official to isolate or quarantine?</li> </ul>	<input type="checkbox"/>  <input type="checkbox"/>	<input type="checkbox"/>  <input type="checkbox"/>
<p><b>Do you currently have any of the following symptoms:</b></p> <ul style="list-style-type: none"> <li><b>Chills</b> or <b>Fever</b> of 100 degrees or higher</li> <li>Loss of <b>Taste</b> or <b>Smell</b></li> <li><b>Muscle Soreness</b> or <b>Headaches</b></li> <li><b>Cough</b> or <b>Runny Nose</b> or <b>Sore Throat</b></li> <li><b>Difficulty Breathing</b> or <b>Shortness of Breath</b></li> <li><b>Conjunctivitis</b> (inflammation of eye including redness, itching and tearing) <u>ALONG WITH</u> feeling feverish</li> <li>GI symptoms such as <b>Abdominal Pain</b> or <b>Diarrhea</b> or <b>Nausea</b> or <b>Vomiting</b></li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<p><b>Complete this section if you are NOT fully vaccinated*:</b></p> <ul style="list-style-type: none"> <li>In the past 14 days, have you had close contact with a person known to have COVID-19?</li> <li>Have you traveled in the past 10 days(if you have not had a negative covid test) or 7 days(if you have received a negative covid test at least 3 days after returning) ?</li> </ul> <p><small>*Fully vaccinated means at 2 weeks after your second dose in a 2-dose series, such as the Pfizer or Moderna vaccines, or 2 weeks after a single-dose vaccine, such as Johnson &amp; Johnson's Janssen vaccine</small></p>	<input type="checkbox"/>  <input type="checkbox"/>	<input type="checkbox"/>  <input type="checkbox"/>

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**Patient Verbalized?**

YES  NO

# WELLNESS SCREENING QUESTIONNAIRE (VISITOR)

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## 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**

V 06-29-21