Self Screening Questionnaire

(Based on CDC Covid-19 Screening)

Please read each question carefully	**Please Circle The Answer That Applies To You**	
Have you experienced any of the following symptoms in the past 48 hours? • fever (greater than 99.9°F, or 37.7°C) or chills • cough • shortness of breath or difficulty breathing • fatigue • muscle or body aches • headache • new loss of taste or smell • sore throat • congestion or runny nose • nausea or vomiting • diarrhea • Eye redness with or without discharge	**Yes**	**No**
Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 15 minutes) with a person who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19?	**Yes**	**No**
Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	**Yes**	**No**
Did you answer No to all of the questions?	If you answered no to all questions, then you may arrive on campus.	
Did you answer Yes to any one question?	If you answered yes to any one question then please stay at home, contact your physician for further instructions, including information about Covid-19 testing.	