VISITOR/VENDOR COVID-19 SCREENING FORM

Name:_____ Department/Purpose:_____

Date:_____ Time:_____

Phone number:_____

Email address:_____

Vendor Name if Applicable:_____

COVID-19 Screening for Visitors		
1. Without fever-reducing medication, are you experiencing a fever greater than 100.4 degrees Fahrenheit or 38 degrees Celsius?	▢ No	▢ Yes
2. Do you have chills?	▢ No	▢ Yes
3. Do you have an undiagnosed cough, shortness of breath, difficulty breathing or sore throat?	▢ No	▢ Yes
4. Do you have unattributable body/muscle aches or fatigue?	▢ No	▢ Yes
5. Do you have unattributable congestion or runny nose?		
6. Do you have a new loss of smell or taste?	▢ No	▢ Yes
7. Do you have vomiting or diarrhea (3 or more loose, watery stools in 24 hours)?	▢ No	▢ Yes
8. Is anyone in your household awaiting a COVID-19 test result due to unattributable COVID-like symptoms or testing due to close contact with a positive COVID-19 case?	▢ No	▢ Yes
9. In the past 14 days, have you or a household member been diagnosed with COVID-19 or asked to home quarantine?	▢ No	▢ Yes
10. Non-essential out-of-state travel requires a quarantine period before returning to campus. (14 days (safest), 10 days, or 7 days with negative COVID-19 test on day 5 or later). Have you traveled out-of-state in the past 2 weeks?	▢ No	▢ Yes, and completed a 14-day quarantine ▢ Yes, and completed a 10-day quarantine ▢ Yes, and completed a 7-day quarantine w/neg Covid-19 test day 5 or later w/test results sent to CG. ▢ Yes, and still in quarantine