ACADEMIC CAMPUS – HEALTH SCREENING QUESTIONNAIRE

Date (Month/Day/Year): _____ Time: _____

Name:	☐ **Employee** ☐ **Visitor** ☐ **Student**
Phone Number (required for all visitors):	

	Representations
1	Do you currently have (or have had in the last 10 days) one of more of these new or worsening symptoms? Yes ☐ No ☐ A temperature greater than or equal to 100° F Yes ☐ No ☐ Feel feverish or have chills Yes ☐ No ☐ Cough Yes ☐ No ☐ Shortness of breath or trouble breathing Yes ☐ No ☐ Fatigue / Feeling or tiredness Yes ☐ No ☐ Muscle pain or body aches Yes ☐ No ☐ Headaches Yes ☐ No ☐ New loss of taste or smell Yes ☐ No ☐ Sore throat Yes ☐ No ☐ Nasal congestion / runny nose Yes ☐ No ☐ Nausea, diarrhea, vomiting
2	In the past 10 days, have you received a positive test result for COVID-19? Yes ☐ No ☐
3	In the past 10 days, have you been tested for COVID-19 (due to referral) and are still waiting for results? Yes ☐ No ☐
4	In the past 14 days, have you been designated as a contact of a person who tested positive for COVID-19 by the local health department? Yes ☐ No ☐
5	In the past 14 days, have you recently traveled internationally to a CDC level 2 or level 3 COVID-19 related travel health notice country or from a state or territory on the NYS Travel Advisory List? Yes ☐ No ☐

This Section Is To Be Completed By The Health Screener

Is the person's temperature above 100° F? Yes ☐ No ☐

* Any positive responses to this questionnaire will result in denial of access into the building.

Access to building / worksite (Check One): ☐ Approved ☐ Denied

Health Screener Signature: _____

Electronically Logged
(Initials)

Note: The information on this form is maintained as confidential.