



COVID-19 WELLES FORM

To be completed daily, prior to any on-campus activity

Name: _____

Contact Number: _____

Date: _____ Campus/Site _____

1. **Temperature taken at point of entry:** _____

2. **Do you have a cough?** Yes No

3. **Are you Short of Breath?** Yes No

If yes:

When? _____

Have you been in contact with a healthcare provider? Yes No

4. **Have you traveled in the past 14 days?** Yes No

If yes:

Where? _____

When? _____

5. **Have you been in contact with anyone who has been diagnosed with COVID-19?** Yes No

If yes, when: _____

6. **Have you been in contact with anyone that has had a cough, shortness of Breath or a fever in the past 14 days?** Yes No

If Yes, when:
