COVID-19 WELLNESS 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:

   _____

   _____