WELLNESS SCREENING QUESTIONNAIRE (VISITOR)

Your safety is our priority. We are screening employees, students, and visitors for signs of virus. Please answer the questions below, provide your name and date. Thank you!

EZID Label

	YES	NO
• In the last 10 days have you, yourself, had COVID-19?	☐	☐
• In the past 14 days, have you had close contact with a person known to have COVID-19?	☐	☐
• Are currently directed by a healthcare provider or public health official to isolate or quarantine?	☐	☐
Do you currently have any of the following symptoms:		
• **Chills** or **Fever** of 100 degrees or higher	☐	☐
• Loss of **Taste** or **Smell**	☐	☐
• **Muscle Soreness** or **Headaches**	☐	☐
• **Cough** or **Runny Nose** or **Sore Throat**	☐	☐
• **Difficulty Breathing** or **Shortness of Breath**	☐	☐
• **Conjunctivitis** (inflammation of eye including redness, itching and tearing) ALONG WITH feeling feverish	☐	☐
• GI symptoms such as **Abdominal Pain** or **Diarrhea** or **Nausea** or **Vomiting**	☐	☐

CONTACT ON CAMPUS:

Contact on Campus Name _____ *Contact on Campus Phone Number* _____

Contact on Campus Email Address _____

Location of Campus Visit _____

Print Name _____ *Phone Number* _____

Email Address _____ *Date* _____

Signature _____

Patient Verbalized?

YES ☐ ***NO*** ☐

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