COVID-19 HEALTH SCREENING

Date of screening: _____ Time of Screening: _____

Visitor name: _____

Have you traveled outside of the United States in the past 14 days? YES NO

Have you had any exposure to someone with or under investigation for COVID-19? YES NO

Part A:

DO YOU HAVE NEW ONSET OF ANY OF THE FOLLOWING SYMPTOMS?		
	YES	**NO**
NEW COUGH		
SHORTNESS OF BREATH OR DIFFCULTY BREATHING		
RECENT LOSS OF TASTE OR SMELL		

Part B:

DO YOU HAVE NEW ONSET OF ANY OF THE FOLLOWING SYMPTOMS?		
	YES	**NO**
FEVER		
CHILLS		
MUSCLE OR BODY ACHES		
HEADACHE		
SORE THROAT		
FATIGUE		
CONGESTION OR RUNNY NOSE		
NAUSEA OR VOMITING		
DIARRHEA		

If you have at least one of the symptoms in Part A above or two of the symptoms in Part B above, you are NOT permitted access to the Salve Regina University campus. Please consult with your personal care practitioner.