COVID-19 related Screening & Guidance

Date_____ Campus Location/Project_____

Participant_____

Questions: (If a response to any of questions 2 through 8 is yes, reschedule the work/meeting/visit to another time.):

1. Are you fully vaccinated?
   Yes_☐ No_☐ Prefer not to answer_☐ - If answer is "yes", skip to question 8.

Are you experiencing now, or have you experienced in the past 14 days any of the following symptoms

2. Cough or sore throat?
   Yes_☐ No_☐

3. Fever or are feeling feverish?
   Yes_☐ No_☐

4. Shortness of breath?
   Yes_☐ No_☐

5. Loss of taste or smell?
   Yes_☐ No_☐

6. Have you been around anyone exhibiting these symptoms within the past 14 days?
   Yes_☐ No_☐

7. Are you living with or have you come in close contact with anyone who is sick or quarantined?
   Yes_☐ No_☐

8. Has a healthcare professional recommended that you isolate or quarantine in the past 14 days?
   Yes_☐ No_☐

Guidance:

- Face coverings are required while indoors on campus, regardless of vaccination status
- Refer to published guidelines and recommendations for further information.