TEAM NAME: TEMPERATURE:

USAU COVID-19 Screening Questionnaire

1. Have you or anyone in your household tested positive for COVID-19 in the last 14 days?

2. In the past 2 weeks, have you traveled out of state?

   a. If yes, what state(s) did you go to?

3. Have you or any close contacts experienced any one (1) of the following symptoms in the last 14 days?
   - Cough
   - Shortness of breath or difficulty breathing
   - Fever or chills
   - New loss of taste or smell

   OR, at least two (2) of the following symptoms:
   - Congestion or runny nose
   - Fatigue
   - Headache
   - Muscle or body aches
   - Sore throat
   - Nausea or vomiting
   - Diarrhea
   - Conjunctivitis (pink eye)
   - New rash

If yes to any of the above, further assessment is needed and participation is prohibited until cleared by a medical provider.

Print Name: ____________________________________Date: ___________

Signature: (parent or guardian if under 18 y.o.) ______________________________________

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