CoVid Screening Form

Name: _____ Date: _____

Address: _____ County: _____

_____ Phone: _____

Date of birth: _____ Sex: M F

Email: _____ Measured Temp: _____

Home Campus:_____ Last on campus: _____

Student ID 900_____

1. **Are you currently experiencing any of the following symptoms?**
   - ☐ Fever (100.4F or greater measured by a thermometer?
   - ☐ Chills, without fever
   - ☐ New or worsening cough
   - ☐ Shortness of breath or difficulty breathing
   - ☐ Sore throat
   - ☐ New loss of taste or smell
   - ☐ Headache
   - ☐ Body Aches
   - ☐ Nausea
   - ☐ Vomiting
   - ☐ Diarrhea
2. **In the past 14 days, have you been in close proximity of anyone who tested positive for CoVid-19?**
   - ☐ Yes
   - ☐ No
3. **In the past 14 days, have you been in close proximity of anyone experiencing any of the above symptoms?**
   - ☐ Yes
   - ☐ No
4. **Have you been tested for CoVid-19 and are awaiting test results?**
   - ☐ Yes If yes, where? _____ When? _____
   - ☐ No
5. **Have you ever tested positive for CoVid-19?**

   Yes/No If yes, when? _____
6. **On what date did your symptoms begin?** _____

If you need this document in an alternate format for accessibility purposes (e.g. Braille, large print, audio, etc.), please contact student health at stuhealthgvl@ung.edu or 678- 696-2676.

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