Patient Screening Form

Are you a currently enrolled student? ☐Yes ☐No

Name: _____ Date: _____

Local Address: _____ County: _____

_____ Phone: _____

Date of birth: _____ Sex: Male Female

School email: _____ Last on Campus: _____

Campus: _____ Athlete/Corps: _____

Dorm: _____ Race: _____

Student ID: 900_____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

☐ Have you traveled or been around someone who has traveled outside the USA in the past 21 days? ☐Yes
If yes, where was the travel to/from? _____ ☐No

1. Are you currently experiencing any of the following symptoms?
   - ☐ Fever (100.4 F, 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
   - ☐ Weakness or Fatigue
   - ☐ Abdominal Pain
   - ☐ Nasal Congestion/drainage

2. On what date did your current symptoms begin? _____
3. In the past 14 days, have you been in close proximity of anyone who tested positive for CoVid-19?
   ☐Yes ☐No
4. Have you ever been tested for CoVid-19?
   ☐Yes ☐No If yes, date last tested? _____
5. Have you ever tested positive for CoVid-19?
   ☐Yes If yes, when? _____ ☐No
6. Have you been vaccinated for Covid-19?
   ☐Yes If yes, when? _____ ☐No

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