TEAM NAME:

USAU COVID-19 Screening Questionnaire

1. Have you, anyone in your household, or any close contacts been diagnosed with or suspected to have COVID-19 in the last 14 days?

2. Have you experienced any one (1) of the following symptoms in the last 2 days?
    - Cough (more than usual)
    - Shortness of breath or difficulty breathing
    - Fever (>-100°F) or chills
    - New loss of taste or smell
    - Congestion or runny nose (more than usual)
    - Fatigue that is unusual and more severe than normal
    - Headache (more than usual)
    - Muscle or body aches (not due to exercise)
    - Scratchy or painful sore throat
    - Nausea or vomiting
    - Diarrhea
    - Eyes are unusually red or painful
    - 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 years of age.) _______________________________________

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