VISITOR DAILY SELF-ASSESSMENT QUESTIONNAIRE RELATED TO COVID-19 (as of 4.1.2021)

This questionnaire is not meant to take the place of consultation with your health care provider or to diagnose or treat conditions. If you are in an emergency medical situation*, call 911. Please answer all questions.

Information about COVID-19 is constantly changing. For current updates on COVID-19 and details on testing and other health measures, check with your local public health agency and visit the CDC website at [www.CDC.gov](http://www.CDC.gov)

Have you tested positive for COVID-19 within the last fourteen (14) days?

☐ Yes, IF YES, DO NOT ENTER CAMPUS.

☐ No

In the last fourteen (14) days, have you been in contact within six (6) feet of a person with a lab-confirmed case of COVID-19 for at least fifteen (15) minutes, or had direct contact with their mucus or saliva, within two (2) days of them being diagnosed?

☐ Yes  ☐ No

In the last 48 hours, have you had any of the following NEW symptoms?

☐ Fever of 100 F (37.8 C) or above, or possible fever symptoms like alternating chills and sweating

☐ New or worsening Cough

☐ Trouble breathing, shortness of breath or severe wheezing*

☐ Tight feeling in chest*

☐ Chills or repeated shaking with chills

☐ Muscle aches

☐ Sore throat

☐ Loss of smell or taste, or a change in taste

☐ Nausea, vomiting or diarrhea

☐ Headache **(does not respond to conventional medications such as Tylenol or Ibuprofen – Advil, Motrin) and usually accompanied by any of the additional symptoms listed above

☐ None of the above

NOTE**: A headache along with sneezing, watery eyes, stuffy or runny nose could indicate seasonal allergy symptoms. If you have questions regarding these symptoms or any illness, please contact your health care provider. *If yes, are the symptom(s), such as sore throat or headache, related to another medical issue?*

☐ Yes  ☐ No  ☐ Not applicable

Within the last fourteen (14) days, have you returned from traveling to any other state or country?

☐ Yes  ☐ No

If “yes”, have you followed the updated NYS guidelines for domestic travel?


OR CDC guidelines for international travel?


☐ Yes  ☐ No

Print Name:_____________________________________________

Telephone number (include area code) ________________________________ (required for contact tracing)

Signature:____________________________________________________