

COVID-19 DAILY SELF-SCREENING CHECKLIST - STUDENT

Complete your COVID-19 Daily Self-Screening Checklist each day before leaving your residence room or coming to campus. This questionnaire is for reference and does not need to be submitted. Check your temperature and answer these screening questions.

If you answer YES to any of these questions DO NOT GO TO CLASS, PRACTICE OR THE DINING HALL.

1.	Do you have a fever (temperature over 100.4° F) without having taken any fever-reducing medications?								
		Yes							
		No							
2.	Do you l	nave any of the followi	ng sympto	oms WITH AN UNKN	OWN ca	use (not due to ast	thma, se	easonal allergies, sinusitis, etc	.):
New or		or worsening cough?	Chills or fatigue?		Shortness of breath?		New loss of taste or smell?		
		Yes		Yes		Yes		Yes	
		No		No		No		No	
Musc		e or body aches?	Headache or sore throat?		Runny or stuffy nose?		Nausea, vomiting, or diarrhea?		
		Yes		Yes		Yes		Yes	
		No		No		No		No	
If v	ou renly	No YES to ANY of the que	stions abo	ove. STAY IN ROOM/	HOMF a	nd:			
11 Y	ou reply	•					tice/wo	.rle	
		•		•	•	-	•		
 Step 3: Follow guidance given in Step 2 and monitor your symptoms. Seek emergency care if you trouble breathing, 								y care if you develop.	
			-	ssure in your chest,					
		o inability to s	=	=					
		o new confusi	=	·,					
		bluish lips of	-						
		CALL 911 or CALL AH	EAD TO LO	CAL EMERGENCY RO	OOM.				

Continue the following preventative measures daily:

Physical distancing Wear a face covering Practice frequent handwashing

Stay home when sick Cover your cough and sneeze in your sleeve/elbow Clean all high-touch surfaces regularly

DO YOUR PART TO HELP KEEP OUR CAMPUS HEALTHY!