Daily COVID-19 Screening Form

Name: ___________________________________________   Date: __________________________

Birth Date: ___________________________   Phone Number: ____________________________

E-mail: ________________________________  Program Name: _________________________________

If the individual referenced above is currently displaying symptoms related to COVID-19, has tested positive for COVID-19 in the past fourteen (14) days, or has come in contact with someone with a suspected or confirmed case of COVID-19 in the past fourteen (14) days please do not come to campus in order to protect the health and safety of the entire University of Alabama community.

_____ Yes ______ No Have you travelled outside of Alabama within the last 14 days?

Locations: ___________________________________________________________________

_____ Yes ______ No Temperature > 100.4? _________ Recorded Temperature

_____ Yes ______ No Have you had contact* with a person with a confirmed or suspected case of COVID-19?

*Contact is defined as less than 6 feet separation for more than 15 minutes without adequate personal protective equipment.

_____ Yes ______ No Have you had a fever within the last 14 days?

_____ Yes ______ No Have you had a forceful dry cough or productive cough within the last 14 days?

_____ Yes ______ No Have you had difficulty breathing or shortness of breath within the last 14 days?

_____ Yes ______ No Have you had chills or repeated shaking with chill within the last 14 days?

_____ Yes ______ No Have you had new unexplained muscle pain within the last 14 days?

_____ Yes ______ No Have you had new or atypical headache for you within the last 14 days?

_____ Yes ______ No Have you had nausea, vomiting or diarrhea within the last 14 days?

_____ Yes ______ No Have you had a sore throat within the last 14 days?

_____ Yes ______ No Have you been tested for COVID-19 in the last 2 weeks?

_____ Yes ______ No Have you had a recent sudden loss of taste or smell?

Anyone who answers yes to any of the above questions should leave campus and seek medical advice or care.
Additional Notes:

______________________________________________________________

______________________________________________________________

For internal program use only: (to be determined by Program Director)

______ Cleared for program entry    ______ Denied for program entry*

*Provide a brief explanation:

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________