NASSAU COMMUNITY COLLEGE DAILY COVID-19 SCREENING FORM

NAME: _____ EMAIL: _____ NCC ID# (if available):_____

BUILDING/LOCATION TO BE VISITED ON CAMPUS: _____

PHONE NUMBER: _____DATE: _____ TIME ENTERING NCC: _____

Please check YES or NO as applicable for each of the questions below:	**YES**	**NO**
1. Do you have a temperature of 100 degrees Fahrenheit or higher?	☐	☐
2. In the past 10 days, have you tested positive for COVID-19, or are you currently awaiting test results for COVID-19?	☐	☐
3. Do you have today, or have you had in the past 14 days any one or more of the following symptoms that you cannot attribute to other known health conditions, such as asthma, migraine headaches, or allergies? ▪ Fever or Chills ▪ Cough ▪ Diarrhea ▪ Shortness of breath or difficulty breathing ▪ Fatigue ▪ Muscle pain or body aches ▪ Headache ▪ Sore throat ▪ New loss of taste or smell ▪ Congestion or runny nose ▪ Nausea	☐	☐
4. In the past 10 days, have you knowingly been in close contact with anyone who has tested positive for COVID-19 or has symptoms of COVID-19?	☐	☐

If you checked "YES" to any of the questions # 1 through #4: <u>Do NOT enter the campus</u> unless you are exempt from quarantine (see info below). Contact your healthcare provider if you are experiencing any COVID-19 symptoms.

I affirm and certify that all the information and answers to the questions herein are accurate to the best of my knowledge and belief. _____ _____

Signature Date