**COVID-19 PRE-SCREENING QUESTIONNAIRE FOR PERSONS WITH SUSPECTED SYMPTOMS**

The safety of our students, faculty, staff and visitors is our priority. To prevent the spread of the coronavirus (COVID-19) and reduce the potential risk of exposure to our students, faculty, staff and visitors, we are asking everyone who has symptoms of the virus to complete this simple questionnaire and submit **BEFORE** deciding to proceed to Campus.

**Kindly respond to each of the following questions to the best of your ability.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date: Click or tap to enter a date. | | | | | |
| Name: Click or tap here to enter text. | | | | | |
| Student/Employee ID/National ID: Click or tap here to enter text. | | | | | |
| Contact number: | | | | | |
| **QUESTIONS** | | | | | |
| 1. To the best of your knowledge, have you been near any individual who tested positive for COVID-19? | | | | Yes  No | |
| 1. Have you or anyone in your household cared for an individual who is in quarantine or is presumed positive within the last 14 days? | | | | Yes  No | |
| 1. Have you been in close contact; less than six feet away and for more than 10 mins; with a person(s) having the following symptoms (tick yes/no):  * Fever | | | | Yes  No | |
| * Cough | | | | Yes  No | |
| * Vomiting | | | | Yes  No | |
| * Diarrhoea | | | | Yes  No | |
| * Lost sense of smell or taste * Other flu symptoms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Yes  No | |
| 1. Have you ever done a Covid-19 test? | | | | Yes  No | |
| 1. If yes (to question 6) please state,   the date Click or tap to enter a date.  and results Choose an item.  **(Please share a copy of the result in the email)** | | | |  | |
| 1. Are you experiencing any of the following signs/symptoms  (tick yes/no):  * Sore throat | | | | Yes  No | |
| * Cough | | | | Yes  No | |
| * Chills | | | | Yes  No | |
| * Body aches | | | | Yes  No | |
| * Shortness of breath | | | | Yes  No | |
| * Loss of smell | | | | Yes  No | |
| * Loss of taste | | | | Yes  No | |
| * Fever at or greater than 100 degrees Fahrenheit | | | | Yes  No | |
| 1. Are you experiencing any pain? | | Yes  No | |  | |
| If yes, please specify:   * Muscular | | Yes  No | |
| * Chest | | Yes  No | |
| * Abdominal | | Yes  No | |
| When did this pain begin? | Click or tap here to enter text. | |  |  |  |
| 1. Have you taken fever medication recently? | | | | Yes  No | |

I attest that the above information is truthful and accurate. I also pledge to follow all the University’s policies and procedures to minimize the risk of COVID-19 transmission, including wearing a mask **ALWAYS** when on the University of Guyana’s campus.

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature**: |  | **Date:** | Click or tap to enter a date. |

**FOR OFFICIAL USE**

**Assessment**

Student/visitor/staff not at appreciable risk for being positive or exposed to Covid-19 and is cleared for entry onto campus yes  no

If no, check below assessment that applies:

1. High probability exposure could have occurred
2. Suspected case
3. Probable case
4. Confirmed case

**ACTION IN THE EVENT STUDENT/VISITOR/ STAFF WAS NOT CLEARED FOR ENTRY ONTO CAMPUS**

|  |  |  |
| --- | --- | --- |
| 1. Referred to Covid-19 hotline | Click or tap here to enter text. |  |
| 1. Referred to health facility | Click or tap here to enter text. |  |

**INFORMATION OF UG PERSONNEL COMPLETING   
THE FORM**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name: | Click or tap here to enter text. | | | | | |
| Staff Category (Designation): | | | | Click or tap here to enter text. | | |
| Date Form Submitted: | | | Click or tap to enter a date. | | Reviewed Date: | Click or tap to enter a date. |
|  | | | | |  | |
| Signature: | |  | | | | |