THIEL COLLEGE

COVID-19 Screening Form

Please email to Health_Services@thiel.edu **7 days prior** to campus arrival
or fax to (724) 589-2875

Last Name	First Name	Middle Initial	Gender ☐M ☐F	Date of Birth	Age

Thiel ID Number	Cell Phone Number

Home Address

Sport (If Applicable)

Within the last 14 days, did you experience, or are you currently experiencing any of the following:

SYMPTOM	YES	NO	LENGTH OF SYMPTOM	DATE OF ONSET
Fever of 100 degrees or higher				
Cough				
Sore Throat				
Shortness of Breath				
Chills/Aches				
Headache				
GI (i.e. nausea vomiting, diarrhea)				
Congestion/Runny Nose				
Loss of Taste				
Loss of Smell				
Fatigue				

QUESTION	Yes	No	N/A
2-14 days prior to experiencing the above symptoms, were you exposed to COVID-19?			
Have you completed COVID-19 vaccination? **If "Yes", date completed** _____ **& please attach proof of vaccination.**			
Have you had close contact with someone **suspected** of having **or** a lab **confirmed** case of COVID? **If "Yes", what was the date of last contact?** _____			
Have you ever tested positive for COVID? **If "Yes", what was the date of your test?** _____			

Have you been tested for COVID-19 within the last 30 days? ☐Yes ☐No

If "Yes" was your test result positive? ☐Yes ☐No

ATTACH COVID TEST DOCUMENTATION IF A COVID TEST WAS PERFORMED WITHIN THE LAST 30 DAYS

Please list any countries/states/cities you have traveled to **within the past month**, and the dates you were there:

1. _____ Dates: _____
2. _____ Dates: _____
3. _____ Dates: _____
4. _____ Dates: _____
5. _____ Dates: _____

Student Signature:_____ Date:_____

Print Name: _____ Parent Signature (if under 18):_____