**STUDENT ACKNOWLEDGEMENT TO RETURN TO CAMPUS**

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| --- | --- | --- | --- |
| **NAME:** |  | **DATE:** |  |
| **EMAIL:** |  | **PHONE:** |  |

Temperature Reading Under 100⁰ : Temp: \_\_\_\_\_\_\_\_ YES\_\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_\_

In the past 24 hours, have you experienced:

Fever YES\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_

Fatigue YES\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_

Cough YES\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_

Sneezing YES\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_

Aches & Pains YES\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_

Runny or Stuffy Nose YES\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_

Sore throat YES\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_

Diarrhea YES\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_

Headaches YES\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_

Shortness of breath YES\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_

Chills/Repeated Shaking with Chills YES\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_

Loss of Taste or Smell YES\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_

Have you recently been in close contact with anyone who has exhibited any symptoms? YES\_\_\_\_ NO \_\_\_\_

Have you recently been in contact with anyone who has tested positive for COVID-19?  YES\_\_\_\_ NO \_\_\_\_

Have you recently traveled to a restricted area that is under a Level 2, 3, or 4 Travel Advisory according to the US State Department? YES\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_

If you answered YES to any of the above items, please explain below:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_