



Novel Coronavirus (COVID-19) Visitors Survey

Mount St. Mary's University is making every effort to ensure the safety and well-being of our students, employees, and visitors during this pandemic. We ask your cooperation by completing this short questionnaire. The information in this questionnaire will be used and disclosed solely for the purposes of determining your safety and the safety of others during the COVID-19 pandemic.

Please ensure at all times that you are following the posted safety protocols, i.e. wear a face covering, remain physically distant, observe proper handwashing and sanitizing procedures.

The questionnaire intends to identify **NEW** symptoms or **worsening** of symptoms that could be related to the SARS Co-V-2 virus. Symptoms related to pre-existing conditions or allergies are excluded from this questionnaire.

Please complete this survey within 24 hours prior to your arrival.

Printed Name: _____ Today's Date: _____

Signature: _____

Phone Number: _____ Email: _____

Risk Assessment Screening Questions:

1. Have you tested positive for COVID-19 within the past 14 days?	YES	NO
2. Are you fully vaccinated for COVID-19? <i>If you are fully vaccinated, you may skip all of the remaining questions and you are permitted on campus.</i>	YES	NO
3. Have you traveled outside of the U.S. or from a state with a current COVID-19 travel restriction in the past 14 days?	YES	NO
4. Have you or anyone in your household had close contact (face to face contact within 6ft.) with a confirmed or probable case of COVID-10 in the past 14 days?	YES	NO
If you have been exposed to someone with COVID-19 symptoms or who tested positive, please provide the date of last contact:		
5. Have you had any of the following symptoms?		
New fever (100.4 or higher) or a sense of having a fever	YES	NO
New muscle aches that you cannot attribute to another health condition or that may have been caused by a specific activity, such as physical exercise	YES	NO
New shortness of breath that you cannot attribute to another health condition	YES	NO
New sore throat that you cannot attribute to another health condition	YES	NO
New respiratory symptoms such as sore throat, runny nose/nasal congestion or sneezing that you cannot attribute to another health condition	YES	NO
New chills or repeated shaking with chills that you cannot attribute to another health condition	YES	NO
New loss of taste or smell that you cannot attribute to another health condition	YES	NO
New cough that you cannot attribute to another health condition	YES	NO
Nausea, vomiting, diarrhea that you cannot attribute to another health condition	YES	NO

If you answered "YES" to any of the questions 1, 3, 4 or 5, you will not be permitted to proceed at this time and you should self-quarantine. If you answered "NO" to all of the questions 1, 3, 4 and 5 above, you can proceed.