Clinton Community College
Health Screening Questionnaire

NAME:_____

DATE: _____Time:_____

Phone Number:_____

	YES/NO
In the past 14 days, have you tested positive for the virus, and/or had close contact with a confirmed or suspected case of COVID-19?	
In the past 14 days, have you travelled to any of the restricted/advisory States as listed by governor's office?	
Have you experienced any of the following symptoms:	
1. **Cough, shortness of breath or difficulty breathing**	
2. **At least two of the following symptoms, fever of 100.4 F or higher, chills, repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste and/or smell?**	

Please print it out and bring with you to campus to submit when you enter the building. Thank you!