COVID-19 SCREENING FORM

Name:___________________________________   Date:______________________________

Reason for Visit:_______________________________________________________________
____________________________________________________________________________

Email:______________________________ Phone Number:____________________________

Hope Contact:________________________________________________________________

1. Have you had any of the following COVID-19 symptoms in the past 2 weeks?
Fever -- Cough -- Shortness of breath or difficulty breathing -- Shaking chills -- Chest pain,
pressure or tightness -- Fatigue or difficulty with exercise -- Loss of taste or smell -- Persistent
muscle aches or pains -- Sore throat -- Nausea, vomiting, or diarrhea -- Congestion or runny
nose

2. In the last 14 days, are you aware of having any exposure to someone with a diagnosis
(either suspected or confirmed) of COVID-19?

By signing this form you acknowledge that you can answer “no” to the above questions.

Additionally, you acknowledge that while you are at Hope College you will wear a face
covering within six (6) feet of any other individual, in all shared spaces (including all in-
person meetings regardless of distance from other attendees), and in all restrooms and
hallways.

__________________________________________________      _______________________
Signature        Date

Submit a scanned copy or picture of this form to Hope College at campushealth@hope.edu.