

**Daily Screening Document**

**For Visitors and Service Providers for Research-related Activities**

***VISITOR SHOULD COMPLETE DAILY SCREENING DOCUMENT AND PROVIDE TO HOST WITH DAILY UPDATES AS APPROPRIATE.***

***HOST, VISITOR AND COMPANY/INSTITUTION NAME (Include contact information):***

***DATE(S) OF VISIT and CAMPUS SITE FOR VISIT:***

**In the past 48 hours, or since your last visit to a Wayne State University facility, have you experienced any of the following NEW symptoms? (please check all that apply)**

[ ]  Fever (100.4 F or higher) or a sense of having a fever?

[ ]  Cough that you cannot attribute to another health condition?

[ ]  Shortness of breath that you cannot attribute to another health condition?

[ ]  Sore throat that you cannot attribute to another health condition?

[ ]  Muscle aches that you cannot attribute to another health condition or that may have been caused by a specific activity, such as physical exercise?

[ ]  Respiratory symptoms, such as sore throat, runny nose/nasal congestion or sneezing that cannot be attributed to another health condition?

[ ]  Chills or repeated shaking with chills that you cannot attribute to another health condition?

[ ]  Loss of taste or smell that you cannot attribute to another health condition?

**Have you had close contact in the last 14 days with an individual diagnosed with COVID-19? *\****

[ ]  Yes [ ]  No

**Have you traveled by airplane internationally in the last 14 days? *\****

[ ]  Yes [ ]  No

**Have you had a COVID-19 test and are awaiting results? *\****

[ ]  Yes [ ]  No

\* Please provide further information to host and responsible individual for site activities.