

**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.