



CIIS Health Screening Questions

1 **Name:**
First Name Middle Name Last Name

We will determine if the employee/student has a fever by Taking their temperature using a contactless temporal thermometer at the front door of CIIS.

2 **Have you felt like you had a fever in the past day?**

YES NO

3 **Do you have any of these [other symptoms](#)?**

- | | |
|--|---|
| <input type="checkbox"/> Shortness of breath or difficulty breathing | <input type="checkbox"/> Muscle or body aches |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Congestion or runny nose | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> New loss of taste or smell | |

4 **Contact Information**

My Email **My Phone**

By signing below, I am acknowledging that I have read the above information and completed the form truthfully and to the best of my knowledge. I also agree to wearing a face covering, observe social distancing and wash hands regularly as directed.

Signature

Date of Signature
MM DD YY