

## Medical Screening Check-in

To be completed prior to project-related travel

Name:	Date:	Departure Date:
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1. At any point in the past two weeks, have you exhibited any of the following symptoms:

	Yes	No	Explain symptom duration & potential cause (allergy, chronic condition)
Fever			
Cough			
Shortness of Breath			

2. Have you recently come into close contact with any individual who has tested positive for COVID-19? Yes \_\_\_\_\_ No \_\_\_\_\_

3. Has any member of your household exhibited any of the following symptoms?

	Yes	No	Explain symptom duration & potential cause (allergy, chronic condition)
Fever			
Cough			
Shortness of Breath			
COVID-positive contact			

4. Within the last 2 weeks, I have not traveled to a restricted (Level 3) area as designated by the CDC. Initial: \_\_\_\_\_

*I confirm that I have reviewed and agree to the guidelines in the "University of Wyoming Reducing Impact of COVID-19 on UW Research" available on the ORED COVID-19 website, [www.uwyo.edu/research/covid-19](http://www.uwyo.edu/research/covid-19)*

Signature of Traveler: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Supervisor: \_\_\_\_\_

Date: \_\_\_\_\_