

## **COVID - 19 HEALTH SCREENING**

NAME	DATE:				
Vendor/Visitor – C	company Name				
Employees and Students	should complete the he	alth screening e-fo	rm available in your Online C	enter/Rave (	Guardian
PRIMARY SYMPTOM CHECK				Please Circle	
Do you have a fever greater than 100F/37.8C?				YES	NO
Do you have a severe cough that started or has gotten worse in the last 48 hours?				YES	NO
Do you have shortness of breath that started in the last 48 hours?				YES	NO
Have you been screened by any medical provider for any of the above symptoms in the past 48 Hours?				YES	NO
Have you had a positive Corona Virus test in the past 10 days?				YES	NO
Have you had close contact with a confirmed / probable COVID-19 case?				YES	NO
SECONDARY SYMPTOM Please select from the follo		have been include	d as secondary symptoms o	f COVID-19:	
Muscle aches Runn		ose	Nasal Congestion		
Sore Throat Nausea/		digestive issues	Feeling more tired than	Feeling more tired than usual	
	t cleared to be on th	ne GRCC campu	selected TWO or more one selected TWO or more one selected TWO or more or selected to the sele		dary
Signature:		P	hone Number:		
		For Office Use (	nly		
Date & Time	of Campus Visit				
Department	s & Buildings				$\neg$

Offices must retain this form 28 days, after which it can be shredded.

## GRAND RAPIDS COMMUNITY COLLEGE

Visited

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