1. Do any of the following symptoms or conditions apply to you?
   - Fever
   - Chills or shivers
   - Muscle pains or aches (not due to exercise)
   - Cough (worse than usual if you have a daily cough)
   - Shortness of breath or trouble breathing
   - Headache (worse than usual if you have headaches)
   - Scratchy or painful sore throat
   - New loss of taste and smell
   - Nausea/vomiting/diarrhea/stomach cramps
   - Dizziness and lightheadedness
   - Sneezing, runny nose, or congestion (worse than usual if this is common for you)
   - Fatigue that is unusual or more severe than normal
   - Eyes are unusually red or painful
   - A member of your household has a confirmed COVID-19 infection or you have been in close contact with someone who had a confirmed COVID-19 infection

   YES  NO

2. I attest that this is an accurate representation of my symptoms and/or conditions.

   YES  NO

3. If I feel that I am unwell, I understand that I should stay at home and not come to work. I should contact my primary care clinician for further evaluation.

   YES  NO

4. I agree to have my temperature taken on entry into my building if it is part of my building's current policy.

   YES  NO

Name:  Date:
Signature:
Instructions for Use:

1. This form must be completed by anyone seeking access to a UC Berkeley site if that person does not have access to the online Daily Symptom Screener.
2. This form must be completed even if the access is for a “quick trip” to retrieve an item from a UC Berkeley site.
3. This form shall be retained in a secure place for 14 calendar days and then destroyed.
4. Questions about this form can be directed to: symptomscreen@berkeley.edu