



UC Berkeley Daily Symptom Screener

(This paper version is for use by individuals without access to the online symptom screener)

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

YES		NO	
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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	
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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	
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Name:		Date:	
Signature:			



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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**