FAIRMONT STATE UNIVERSITY™

Student Health Services
1201 Locust Ave • Fairmont, WV, 26554
Phone: (304) 367-4155 • Fax: (304) 367-4701
fairmontstate.edu

RESIDENCE HALLS SCREENING FORM

Student Name: _____
Last First Middle

Residence Hall and Room Number: _____

Phone Number: (☐☐☐)☐☐☐-☐☐☐☐ DOB: ☐☐/☐☐/☐☐☐☐
Month Day Year

Student ID: ☐☐☐☐ ☐☐☐☐

Guest Names and Phone Numbers: _____
_____
_____

Do you or any of your guests currently have any of the following symptoms within the last 14 days?

1. Fever (100.4°F or higher), or a sense of having a fever. ☐Y ☐N
2. New cough not attributed to another health condition. ☐Y ☐N
3. New shortness of breath not attributed to another health condition. ☐Y ☐N
4. New sore throat not attributed to another health condition. ☐Y ☐N
5. New muscle aches not attributed to another health condition, or that may have been caused by a specific activity. ☐Y ☐N
6. Nausea, vomiting, or diarrhea not attributed to another health condition. ☐Y ☐N
7. Been around anyone other than immediate family without a mask on. ☐Y ☐N
8. Traveled to any areas that are considered "hotspots". ☐Y ☐N
   If yes, where (bars, beaches, out of state): _____
9. Have you, any of your guests, or anyone in your/their homes had contact within the last fourteen (14) days with any person under screening/testing for COVID-19, or with anyone with known or suspected COVID-19? ☐Y ☐N

Nurse Notation:
Student Temperature: _____ Guest(s) Temperature(s): _____

Nurse Signature: _____