Name: _____

PUC ID#: _____

Pacific Union College

Return this form to:
Pacific Union College
Health Services
One Angwin Avenue
Angwin, CA 94508
Attn: Health Services

Phone 707.965.6339
Fax 707.965.6243
Instructions:

Send this form with the patient to the provider where they were sent (i.e.: Health Services, hospital, MD office).

COVID-19 Initial Screening Questionnaire

To continue our efforts to protect the PUC community, all faculty, staff, and students returning to campus are initially required to complete the following screening. If you answer YES to any of the following, you will be contacted by PUC's Health Services office for further instructions.

For everyone's health and safety (including yours), you will not be allowed to enter your work building, classroom setting, or dormitory until cleared. If indicated, you may be required to have the bottom portion of this document signed by the medical provider you were directed to see and presented upon your return.

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1. I have had symptoms of a cold and/or flu within the last two weeks Yes/No
2. I have been in close contact with someone with symptoms of a cold or flu-like symptoms within the last two weeks Yes/No
3. I have travelled by air within the last two weeks Yes/No
4. I am currently experiencing the following:
    a. Fever Yes/No
    b. Chills Yes/No
    c. Sore throat Yes/No
    d. Cough Yes/No
    e. Difficulty breathing Yes/No
    f. Headache Yes/No
    g. Muscle aches Yes/No
    h. Abdominal pain Yes/No
    i. Diarrhea Yes/No
    j. Vomiting Yes/No
5. I have been tested for COVID 19 Yes/No
6. I have been tested for SARs COV2 antibodies Yes/No

Date: _____ (I have seen and cleared the above-named individual)

Medical provider name: _____ Title: _____ (MD/PA/NP/RN)

Address: _____

Conditions (if any) for safe return: _____