West Point COVID-19 Screening

1. Please provide your name (Last, First).

_____

2. Please enter today's date (M/d/yyyy)

_____

3. Have you been exposed to anyone with COVID-19 in the last 14 days?

YES / NO

4. Have you traveled outside the US in the last 14 days?

YES / NO

5. Are you experiencing ant COVID-19 symptoms (dry cough, shortness of breath, sudden loss of taste or smell, fever)?

YES / NO