COVID-19 Contact Tracing Questionnaire – CONFIDENTIAL

First Name: _____ Last Name: _____

Date of Birth: _____ Contact Phone Number: _____

E-mail Address: _____

Address: _____

City: _____ Zip: _____

Date you were last on campus or at work: _____

If you are a student, list the classes you are enrolled in: _____, _____, _____, _____, _____

Why did you take a COVID test?

☐ Weekly surveillance testing

☐ I had symptoms Symptom onset date? _____

What were the symptoms? _____

☐ I was recently exposed to someone who had COVID? Where were you exposed?

_____

Other: _____

When did you take your test? _____ Where? _____

Date you notified the district about your positive test? _____

Have you been vaccinated? _____

What type of COVID test did you take?

☐ PCR

☐ Antigen

☐ Other _____

Were you in close contact with anyone (closer than 6 feet for more than 15 minutes) in any of your classes or while on campus? Please describe or list names of individuals if known.

_____