UC Davis Imaging Research Center
COVID-19 Daily Screening

Date: _____

Name: _____
First name MI Last name

e-mail address: _____

Phone number: _____

(Completed forms can be emailed to dmthompson@ucdavis.edu)

1. Which of the following best describes your reason for being here at the IRC?
   - ☐ IRC Staff/Volunteer
   - ☐ Research Investigator, Staff, or Volunteer
   - ☐ Research Participant
   - ☐ Family, Friend, or Driver of Research Participant
   - ☐ Outside Vendor/Contractor
   - ☐ Other (please describe)
2. Do you have any of the following symptoms (in the last 72 hours)?
   - ☐ Difficulty breathing
   - ☐ Fever greater than 100 degrees
   - ☐ Severe fatigue
   - ☐ Diarrhea
   - ☐ Cough (not due to a chronic or known condition)
   - ☐ Nasal congestion (different from pre-existing allergies)
   - ☐ Loss of sense of taste or smell (not due to a chronic condition)
   - ☐ None
3. Have you traveled in the last 21 days?
   - ☐ Yes
   - ☐ No
4. In the last 21 days have you been in contact with a sick person with flu like symptoms?
   - ☐ Yes
   - ☐ No
5. Does a member of your household have a confirmed COVID-19 infection?
   - ☐ Yes
   - ☐ No

Temperature checked by IRC staff member _____
Sign and date