Return to Campus After 14 Day Isolation Period- Clearance Form

Name _____ Class_____ DOB _____
Allergies_____ Cell phone _____
Daily Meds_____
PMHx _____
PSHx _____
Tobacco use: yes no Quit ___ppd/___yrs Vaping: yes no Recreational drugs: yes no _____
Alcohol use: yes no How often do you drink 4(women)/5(men) drinks/day___

Date _____ **Temp___ B/P ___/___ HR ___ RR ___ O2 Sat ___%**
Residency ❒US resident ❒Non-resident, country _____
Date of symptom onset _____ Date of travel _____ Country of Travel _____

Does the patient have the following signs and symptoms (check all that apply)?
❒Fever ❒Cough ❒Sore throat ❒Shortness of breath

Does the patient have these additional signs and symptoms (check all that apply)?
❒Chills ❒Headache ❒Muscle aches ❒Vomiting ❒Abdominal pain ❒Diarrhea
❒Other, specify_____

In the 14 days before symptom onset, did the patient:

Have close contact with a **laboratory-confirmed COVID-19 patient**? ❒Yes ❒No ❒Unknown

A history of travel from **affected geographic areas within 14 days of symptom onset**?
❒Yes ❒No ❒Unknown
Date traveled to _____ Location _____ Date traveled **from** _____
Date arrived in US _____

No source of exposure has been identified? ❒Yes ❒No ❒Unknown

Physician signature;_____ Date: _____