LAU
الجامعة اللبنانية الأميركية
Lebanese American University

COVID-19 Screening Questionnaire

Name: Mobile #:

ID#: Email:

1. Have you or any of your family members or individuals whom you encountered traveled abroad in the past 14 days?

   ○ Yes ○ No

   If yes:

   1- List the country(ies) including airports you visited:

   2- Date(s) of arrival as per your passport:

2. Have you had close contact with a traveler or a COVID-19 confirmed case in the past 14 days?

   ○ Yes ○ No

3. Have you had any contact with people having respiratory infections within the past 14 days?

   ○ Yes ○ No

4. Have you visited a healthcare facility within the past 14 days?

   ○ Yes ○ No

5. Have you had any of these symptoms within the past 14 days?

   - Fever > 37.8 °C ○ Yes ○ No
   - Cough ○ Yes ○ No
   - Difficulty in breathing ○ Yes ○ No
   - Sore throat ○ Yes ○ No

6. Do you have any underlying health condition* or any medical condition that decreases your immunity or requires you to take a medication that decreases your immunity?

   ○ Yes ○ No

   Specify:

*An underlying health condition is a chronic or long-term illness, which in turn weakens the immune system such as cardiovascular disease, diabetes, chronic respiratory disease, and cancer.