

Appendix B **Entrance to Facility Questionnaire**

Are you experiencing any of the following? If so, answer yes to the question "***are you having any symptoms listed on the questionnaire***" asked at the screening point upon entry to the facility.

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

In the past 14 days have you had close contact with someone who is confirmed as having COVID-19?

A close contact is defined as a person who:

- provided care for the individual, including healthcare workers, family members or other caregivers, or who had other similar close physical contact **without** consistent and appropriate use of personal protective equipment OR
 - lived with or otherwise had close prolonged contact (within 6 feet) with the person while they were infectious OR
 - had direct contact with infectious bodily fluids of the person (e.g. was coughed or sneezed on) while **not wearing** recommended personal protective equipment
- If you are NOT fully vaccinated (15 days after 2nd dose of Pfizer or Moderna or 1 dose of Johnson & Johnson vaccines) have you recently traveled to New Jersey from **any U.S. state or territory** beyond the immediate region (New York, Connecticut, Pennsylvania, and Delaware)

If you answer "YES" to any of these questions, you may not be permitted on campus at this time. Please self-quarantine for 10 days from the potential exposure and/or return from outside the immediate region prior to returning to campus.

I _____ confirm that I have answered **NO** to the above questions
(Print Name Clearly) on this date _____.

Staff Use Only: Student/Staff will self-quarantine through _____ (date)