



THE UNIVERSITY OF THE WEST INDIES, MONA

THE UNIVERSITY HEALTH CENTRE

COVID-19 REPORTING FORM

Please complete this form if tested positive for COVID **OR** if you have been placed in quarantine by a medical practitioner. Please submit the results of the test(s) as soon as you have received same to the Clinical Director at tina.hyltonkong@uwimona.edu.jm

Any staff or student showing symptoms should stay away from work/school and contact seek medical attention immediately.

1. Date: __/__/____ dd/mm/yyyy		2. Name:	
3. Sex at birth: Male <input type="checkbox"/> Female <input type="checkbox"/>		4. Date of Birth: __/__/____ dd/mm/yyyy	Mobile Number: Email:
5. Faculty/Dept:		6. ID Number:	
7. Occupation:		8. Hall of Residence (if applicable):	
8. Address in the Past 14 Days:			
9. Have you been exposed to a person confirmed with COVID-19: Yes <input type="checkbox"/> No <input type="checkbox"/>			
If Yes, how Long ago _____			
10. COVID -19 vaccination status None <input type="checkbox"/> Incomplete <input type="checkbox"/> Fully <input type="checkbox"/> Booster <input type="checkbox"/>			
If Yes, please state date of last vaccine: __/__/____ dd/mm/yyyy			
11. Do (did) you have any symptoms of COVID-19: Yes <input type="checkbox"/> No <input type="checkbox"/>			
If Yes, please indicate: Fever <input type="checkbox"/> Cough <input type="checkbox"/> Sore throat <input type="checkbox"/> Headache <input type="checkbox"/> Fatigue <input type="checkbox"/>			
Shortness of breath <input type="checkbox"/> loss of taste <input type="checkbox"/> Other: _____			
12. Date of onset of first symptom if have (had) any: __/__/____ dd/mm/yyyy			