APPENDIX A

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 ☐ Female ☐	**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 ☐ No ☐ **If Yes, how Long ago_____**		
10. COVID -19 vaccination status *None* ☐ *Incomplete* ☐ *Fully* ☐ *Booster* ☐ If Yes, please state date of last vaccine:___/___/___ dd/mm/yyyy		
11. **Do (did) you have any symptoms of COVID-19**: Yes ☐ No ☐ If Yes, please indicate: *Fever* ☐ *Cough* ☐ *Sore throat* ☐ *Headache* ☐ *Fatigue* ☐ *Shortness of breath* ☐ *loss of taste* ☐ *Other:* _____ _____		
12. Date of onset of first symptom if have (had) any::___/___/___ dd/mm/yyyy		

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