



The University of the West Indies, Mona Campus  
Risk Assessment Form for COVID-19 Contact

This form must be completed and submitted immediately to the Clinical Director University Health Centre: [tina.hyltonkong@uwimona.edu.jm](mailto:tina.hyltonkong@uwimona.edu.jm). All healthcare students stationed at UHWI should complete FMS Risk Assessment Form for clinical students and follow the instructions about notifying UHC.

<b>Date of report</b> ____/____/____ dd/mm/yyyy	<b>Name</b>
<b>Contact number:</b>	<b>ID number:</b>
<b>Date of birth</b> ____/____/____ dd/mm/yyyy	<b>Sex at birth</b> Male <input type="checkbox"/> Female <input type="checkbox"/>
<b>Faculty/Dept:</b>	
<b>Address in the last 14 days</b>	
<b>Vaccination Status</b>	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

<b>Are you showing any symptoms of COVID-19?</b>  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: _____	
<b>Date of onset of first symptoms</b> ____/____/____ dd/mm/yyyy	<b>Have you left home since onset of symptoms?</b>	<b>If yes when?</b> ____/____/____ dd/mm/yyyy

<b>Known exposure to COVID-19 positive case?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/> Date of exposure: ____/____/____ dd/mm/yyyy  If yes, was this exposure inside a building? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, was it a small room? Yes <input type="checkbox"/> No <input type="checkbox"/> Was room well ventilated, windows open? Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Working in/visited a clinical setting?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Recent travel?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Ill family member?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Unknown contact</b> <input type="checkbox"/>
<b>Were you wearing a mask?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Was the contact wearing a mask?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>