



# UNIOSUN STUDENT PRELIMINARY ASSESSMENT FORM FOR COVID-19 STATUS.

## Q1. Are you having

- a) a very hard time waking up?
- b) confused feeling?
- c) difficulty in breathing (e.g., struggling for each breath, speaking in single words)?
- d) loss of consciousness?
- e) severe chest pain?

YES

NO

## Q2. Are you having:

- a) shortness of breath at rest?
- b) inability to lie down because of difficulty in breathing?
- c) chronic health conditions that you are managing because of your current respiratory illness?

YES

NO

## Q3. In the last a week and a half, did you experience

- a) fever?
- b) new onset of cough or worsening of chronic cough?
- c) new or worsening shortness of breath?
- d) new or worsening difficulty breathing?
- e) sore throat?
- f) runny nose?

YES

NO

## Q4. Do you experience any of the following:

- a) Chills?
- b) Conjunctivitis (pink eye)?
- c) Feeling unwell, fatigue or severe exhaustion?
- d) Headache?
- e) Loss of sense of smell or taste?
- f) Muscle or joint ache?
- g) Nausea, vomiting, diarrhea or unexplained loss of appetite?
- h) Painful swallowing?

i) Stuffy nose?

YES

NO

**Q5. In the past 14 days, did you return from travel outside of Nigeria, or did you have close contact with someone who is confirmed as having COVID-19?**

YES

NO

STUDENT NAME:

MATRIC NUMBER:

DEPARTMENT:

PHONE:

### UNDERTAKING BY PARENTS/GUARDIAN

I hereby confirm that the information provided above by my child/ward is correct.

PARENT NAME:

SIGNATURE:

DATE:

PHONE:

### FOR OFFICIAL USE ONLY (Clearance form to be detached)

The preliminary assessment for COVID-19 status of the under listed student has been carried out.

S/he should be allowed to participate in all academic activities

NAME:.....

MATRIC NUMBER:.....

DEPARTMENT:.....

FACULTY / COLLEGE.....

Passport Photograph

EXPIRY DATE .....

**Name, Signature, Date and Stamp of Designated Physician**