



COVID-19 Contact Tracing Questionnaire – CONFIDENTIAL

First Name: _____ Last Name: _____ Student ID# _____

If you are a student, list the classes you are enrolled in: _____,
_____, _____, _____

Date of Birth: _____ Contact Phone Number: _____

E-mail Address: _____

Address: _____

City: _____ Zip: _____

Date you were last on campus or at work: _____

Why did you take a COVID test? Check all that apply.

Weekly surveillance testing

I had symptoms Symptom onset date? _____

What were the symptoms? _____

I was recently exposed to someone who had COVID? Where were you exposed?

Other: _____

When did you take your test? _____ Where? _____

Date you notified the district about your positive test? _____

Have you been vaccinated? _____

What type of COVID test did you take?

PCR Antigen Other _____

You are deemed to be infectious from 2 days before you started having symptoms, or if you don't have any symptoms, from 2 days before you took your COVID test.

Were you in close contact with anyone (**closer than 6 feet for more than 15 minutes**) in any of your classes or while on campus and **while infectious**? This could be while eating lunch with someone, in class or in a meeting. Please describe or list names of individuals if known.

