

**East Central University Student Health Services
Confirmed Positive COVID-19 Questionnaire**

1. Contact Information:

- Name: _____
- Address: _____
- Phone Number: _____
- ECU ID #: _____
- ECU email: _____

2. What facility confirmed your positive test? (request copy of test be emailed)

3. What are your current symptoms? (check all that apply)

- Allergy-like ____
- Loss of sense of smell ____
- Loss of sense of taste ____
- Headache ____
- Strep throat like ____
- Stomach issues ____
- Diarrhea ____
- Fever ____ What is it? _____
- Shortness of breath ____
- Coughing ____

4. Demographics (for whom to notify):

- Are you: Faculty _____ Staff _____ Student _____
- Do you live on campus? (Director of Housing)
 - If yes, where _____
- Are you an athlete? (Athletic Director)
 - If yes, which sport _____
- Do you work on campus? (Director of Employment Services)
 - If yes, where _____
- Are you taking face-to-face classes? (Provost) Yes ____ No _____