THE UNIVERSITY OF THE WEST INDIES
MONA CAMPUS, JAMAICA, WEST INDIES

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. All healthcare students stationed at UHWI should complete FMS Risk Assessment Form for clinical students and follow the instructions about notifying UHC.

Date of report ____/____/_____ *dd/ mm/ yyyy*	**Name**
Contact number:	**ID number:**
Date of birth ____/____/_____ *dd/ mm/ yyyy*	**Sex at birth** *Male* ☐ *Female* ☐
Faculty/Dept:	
Address in the last 14 days	
Vaccination Status	*None* ☐ *Incomplete* ☐ *Fully* ☐ *Booster* ☐ If Yes, please state date of last vaccine:___/___/____ dd/mm/yyyy

Are **you showing any symptoms of COVID-19?** **Yes** ☐ **No** ☐	If Yes, please indicate: *Fever* ☐ *Cough* ☐ *Sore throat* ☐ *Headache* ☐ *Fatigue* ☐ *Shortness of breath* ☐ *Loss of taste* ☐ *Other:* _____	
Date of onset of first symptoms ____/____/_____ *dd/ mm/ yyyy*	Have you left home since onset of symptoms?	If yes when? ____/____/_____ *dd/ mm/ yyyy*

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