



## Daily COVID-19 Attestation

Date of visit: \_\_\_\_\_ Time: \_\_\_\_\_  
Duration of visit: \_\_\_\_\_  
Name: \_\_\_\_\_  
Affiliation / Company: \_\_\_\_\_  
Phone / Text Number: \_\_\_\_\_ MIT ID (if available): \_\_\_\_\_

Are you experiencing any of the following symptoms?	Yes	No
Fever or feeling feverish	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
New cough (not related to chronic condition)	<input type="checkbox"/>	<input type="checkbox"/>
New nasal congestion or new runny nose (not related to seasonal allergies)	<input type="checkbox"/>	<input type="checkbox"/>
Muscle aches	<input type="checkbox"/>	<input type="checkbox"/>
New loss of smell	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>

Please answer the following questions:	Yes	No
Have you been tested and had a positive result, or have you been told by a healthcare provider that you are likely positive, for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
Within the last 14 days, have you been in close contact with anyone that you know has been diagnosed with COVID-19 or has had COVID-19 related symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a health care worker who has had contact with a COVID-19 positive individual as part of your work?	<input type="checkbox"/>	<input type="checkbox"/>
Do you agree to wear Personal Protective Equipment (PPE) while engaging in activities on campus?	<input type="checkbox"/>	<input type="checkbox"/>
Do you agree to adhere to all rules and protocols of social / physical distancing while engaging in activities on campus?	<input type="checkbox"/>	<input type="checkbox"/>