Columbia University
Health Screening Form

All visitors and vendors must fill out this form before entering Columbia University Buildings/Locations. This form must be returned to the primary contact person in the department or for your service contract.

Date: ___________________________ Company Name: ___________________________

Vendor/Visitor name: ___________________________ Tel No: ___________________________

University Contact Name: ___________________________ Building/Work Area: ___________________________

- IMPORTANT NOTICE: If you develop symptoms while on the premises, you must immediately leave the campus and contact your employer for appropriate guidance.

To the best of your knowledge, select any of the following:

☐ You have experienced any symptoms of COVID-19 in the past 14 days (fever, cough, shortness of breath or difficulty breathing, chills, repeated shaking with chills, muscle pain, sore throat, abdominal pain/diarrhea, new loss of taste or smell, or other symptoms of COVID-19).

☐ I have been in close contact with a person known to be infected with COVID-19, and have not yet been tested*

☐ My symptoms are mild and self-limiting, and I will wear a mask for 48 hours after my symptoms resolve

☐ My symptoms are severe and/or worsening*

☐ I have been cleared by a healthcare provider, Human Resources or Leave Management to come to campus

☐ I have only fatigue, headache, and/or muscle/joint aches that began within 2 days after COVID vaccination AND lasted for 3 days or less AND I feel well enough to work

☐ I am not vaccinated*

☐ You knowingly have been in close or proximate contact (within 6 feet for more than 10 minutes in a single instance) in the past 14 days with anyone who has tested positive for COVID-19 or who has had symptoms of COVID-19

☐ I have received all recommended vaccine doses, including boosters when eligible, and have no symptoms

☐ I have had confirmed COVID-19 within the last 90 days with a positive viral test

☐ I am not vaccinated, OR have not completed a primary vaccine series, OR I have completed the primary series of recommended vaccine but have not received a recommended booster shot when eligible*

☐ You tested positive for COVID-19 in the past 14 days

(Please check all that apply if you have tested positive for COVID-19 in the past 14 days)

☐ Less than 5 days have passed since onset of symptoms or the date of the positive test (where day 0 is the day of symptom onset or (if asymptomatic) the day of collection of the first positive specimen)*

☐ I have had a fever within the past 24 hours*

☐ My other symptoms have not improved*
*Should these statements be checked, you will not be allowed to enter any University building/location and you should immediately notify your employer.

To the best of my knowledge, I certify that the information submitted on this form is true and correct. Furthermore, I agree to follow all Columbia University safety protocols which currently include wearing face coverings indoors. I understand that failure to comply with safety protocols will result in being asked to leave.

Visitor/Vendor Name (Printed): 

Visitor/Vendor (Signature): 

Questions are from the NY State Interim Guidance for Higher Education Research During the COVID-19 Public Health Emergency.

Source: New York State Department of Health

Updated as of 1/27/22