



# COVID-19 Positive Form

12745 College Drive  
Glenns, VA 23149

Email: [www.covidreporting@rappahannock.edu](mailto:www.covidreporting@rappahannock.edu)

SUBMITTER INFORMATION					
First Name:		Last Name:		Date:	
Email:		Ext.:		Home Phone:	
				Cell:	

COVID-19 POSITIVE INDIVIDUAL INFORMATION					
First Name:		Last Name:		Email:	
Phone:		<input type="checkbox"/> Student <input type="checkbox"/> Staff	Student#:	Are you a Nursing Student: <input type="checkbox"/> Yes or <input type="checkbox"/> No	
Learning /Work Setting:	<input type="checkbox"/> Virtual Class	<input type="checkbox"/> Remote Work	<input type="checkbox"/> In-person class	<input type="checkbox"/> Work on campus	<input type="checkbox"/> Hybrid
Date Last on Campus:		Which Campus:	<input type="checkbox"/> Glenns <input type="checkbox"/> Warsaw <input type="checkbox"/> New Kent County <input type="checkbox"/> Kilmarnock <input type="checkbox"/> King George		
Department:		Course:		Room #:	
Contact Tracing (list the name of every person you were in contact with on campus):					
1.		2.		3.	
4.		5.		6.	
7.		8.		9.	

COVID-19 Information					
Are you fully Vaccinated:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Johnson & Johnson	Date of 1 <sup>st</sup> Vaccination		Date of 2 <sup>nd</sup> Vaccination
Are you having Symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes" date of 1 <sup>st</sup> symptoms?		<input type="checkbox"/> Runny Nose <input type="checkbox"/> Fever or Chills <input type="checkbox"/> Cough <input type="checkbox"/> Nausea or Vomiting <input type="checkbox"/> Loss of taste or Smell <input type="checkbox"/> Sore throat <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Sneezing <input type="checkbox"/> Fatigue <input type="checkbox"/> Muscle or body aches	
Have you taken a COVID-19 Test?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "YES" Date of COVID-19 Test?		Date Received COVID-19 Positive Results?	
Test and Results given by:					
Health Department Notified: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown					If yes Date:
Name of Health Department:					
Did you wear a mask and social distance while on campus? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A					
Where were you exposed?					<input type="checkbox"/> Unknown
Quarantine Period:	# of days:		Start date		End date