COVID-19 Positive Form

12745 College Drive
Glenns, VA 23149
Email: 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:		☐ Student ☐ Staff		Student#:		Are you a Nursing Student: ☐ Yes or ☐ No	
Learning /Work Setting:	☐ Virtual Class ☐ Remote Work		☐ In-person class ☐ Work on campus		☐ Hybrid		
Date Last on Campus:		Which Campus: ☐ Glenns ☐ Warsaw ☐ New Kent County ☐ Kilmarnock ☐ 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:	☐ Yes ☐ No	☐ Pfizer ☐ Moderna ☐ Johnson & Johnson	Date of 1st Vaccination		Date of 2nd Vaccination	
Are you having Symptoms?	☐ Yes ☐ No	If "Yes" date of 1st symptoms?		☐ Runny Nose ☐ Fever or Chills ☐ Cough ☐ Nausea or Vomiting ☐ Loss of taste or Smell ☐ Sore throat ☐ Difficulty Breathing ☐ Sneezing ☐ Fatigue ☐ Muscle or body aches	
Have you taken a COVID-19 Test?	☐ Yes ☐ No	If "YES" Date of COVID-19 Test?		Date Received COVID-19 Positive Results?	
Test and Results given by:					
Health Department Notified: ☐ YES ☐ NO ☐ Unknown				If yes Date:	
Name of Health Department:					
Did you wear a mask and social distance while on campus?	☐ Yes ☐ No ☐ N/A				
Where were you exposed?				☐ Unknown	
Quarantine Period:	# of days:		Start date		End date	