Risk screening questionnaire and statement

Personal data:
Name (in capital letters): ____
Date of birth: ____
Address (actual place of residence in Hungary): ____________________________________
____
Phone (mobile): ____
E-mail:____

Have you experienced any of these symptoms in the last 3 days?

Fever or body temperature above 37,5 C	Yes	No
Headache, malaise, weakness, muscle aches	Yes	No
Dry cough, shortness of breath, rapid breathing	Yes	No
Sore throat, loss of smell / taste	Yes	No
Nausea, vomiting, diarrhea	Yes	No

Have you been in contact with a person with a suspected or confirmed infection with COVID-19 coronavirus (SARS-CoV2)?

Yes Date of last contact: ______________________________________
No

Have you had contact in the last 14 days with a person who has been quarantined on suspicion of COVID-19 infection?

Yes Date of last contact: ______________________________________
No

Have you been abroad within 14 days or have you received guests from abroad?

Yes Date: ____
No

Have you been in contact with a person in the last 14 days, who had a fever, cough, shortness of breath?

Yes Date of last contact: ________________________
No

Have you had SARS CoV2 coronavirus PCR assay test? If so, when was it performed and with what results?

Yes Date and result: 1. ____________________ 2.__________________
No

Have you been quarantined after your arrival to Hungary? If yes, please indicate the location and period?

Yes Location and period: _____________________________________
No

I hereby confirm that all the above statements are true
and
in the event of the onset of any of the symptoms listed above I will immediately notify my general practitioner and follow the instructions of the institutional action plan of the University of Szeged.

Place and date of filling Signature