INDIANA UNIVERSITY SOUTH BEND

HEALTH AND WELLNESS CENTER

I _____ (print name) confirm and acknowledge that I am not experiencing any symptoms of SARS-CoV-2 (Covid-19/Coronavirus) including:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

Patient Signature _____ **Date:** _____

Witness Signature _____ **Date:** _____