



**APPENDIX B**

**THE UNIVERSITY OF THE WEST INDIES  
MONA CAMPUS**

**HEALTH CENTRE**

**COVID 19 CONTACT QUESTIONNAIRE**

**Instructions:** If you have been exposed to a person who has tested positive for COVID 19 please inform your Supervisor, complete and email this form to the Clinical Director at [blossom.anglinbrown@uwimona.edu.jm](mailto:blossom.anglinbrown@uwimona.edu.jm) immediately.

1. Name: \_\_\_\_\_ ID#: \_\_\_\_\_

2. When and where was this contact?

\_\_\_\_\_

3. If this contact was inside a building, please say a bit about the size of the room.

\_\_\_\_\_

4. Were the windows open or the air conditioning on/off?

\_\_\_\_\_

5. What was the nature of this contact?

\_\_\_\_\_

6. How long was this contact?

\_\_\_\_\_

7. Were masks being worn?

\_\_\_\_\_

8. Are you having any symptoms e.g. headache, dry cough, tightness of the chest?

\_\_\_\_\_