West Point COVID-19 Screening

1. Please provide your name (Last, First).

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2. Please enter today's date (M/d/yyyy)

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3. Have you been exposed to anyone with COVID-19 in the last 14 days?

YES / NO

4. Have you traveled outside New York and its contiguous states (PA, NJ, CT, MA, and VT) for more than 24 hours in the past 14 days?

YES / NO

5. Are you experiencing any COVID-19 symptoms (dry cough, shortness of breath, sudden loss of taste or smell, fever)?

YES / NO