



UNIVERSITATEA DE MEDICINĂ ȘI FARMACIE  
"CAROL DAVILA" din BUCUREȘTI



**STUDENTS DAILY SORTING QUESTIONNAIRE FOR UNIVERSITY / CLINIC ENTRANCE**

**In the last 14 days:**

1	Have you come in contact with suspicious or confirmed COVID 19 people?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2	Have you come in contact with people with fever or respiratory symptoms?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3	Have you come in contact with people in solitary confinement or quarantine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4	Have you received a recommendation for quarantine or home isolation from the authorities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5	You have one of the following symptoms:		
	- fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	- cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	- dispnea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	- sore throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	- coryza	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	- asthenia, headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	- myalgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	- anorexia / nausea / vomiting, diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	- loss of smell or loss of taste	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Knowing the provisions of art. 326 of the Criminal Code regarding the false statements and art. 352 of the Criminal Code regarding the failure to fight diseases, I declare on my own responsibility that all the information provided in the questionnaire is complete and true.**

**First /Last Name .....**

**Series: ..... Group:**

**Signature.....**

**Date.....**

**Measured temperature ..... °C**

**Verified by:.....**