UNIVERSITY HEALTH SERVICES

REPORT YOUR COVID-19 POSITIVE RESULT

FIRST NAME: _____ **LAST NAME:** _____

STUDENT ID: _____ **DATE OF BIRTH:** _____

WHERE DO YOU LIVE IN OXFORD? _____

CELL PHONE NUMBER: _____

WHERE WERE YOU TESTED: _____

DATE TESTED: _____

DATE OF SYMPTOMS: _____
(Put N/A if asymptomatic)