STUDENT HEALTH SERVICES
UNIVERSITY OF MISSISSIPPI

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)

HAVE YOU PREVIOUSLY BEEN VACCINATED?

- (●) Yes
- ( ) No

If "Yes" which one:

- ( ) Pfizer
- ( ) Moderna
- ( ) Johnson & Johnson
- ( ) Other _____
- (●) Not Applicable