COVID – 19 SCREENING QUESTIONNAIRE

Please print out and complete this form for each member of your family and bring it with you **every week**. (Please **Print**)

NAME _____

ADDRESS_____

PHONE (H)_____(C)_____

TEMPERATURE_____ (to be taken at church)

Have you been out of the state or country during the last 2 weeks?
Yes ☐ No ☐

Have you come in contact with anyone who has been diagnosed with Covid in the last 2 weeks?
Yes ☐ No ☐

Have you exhibited any of the following symptoms? (shortness of breath, loss of smell or taste, fatigue, fever, chills, dry cough, vomiting, diarrhea, muscle or body aches) Yes ☐ No ☐

Certification

I hereby certify that the responses provided above are true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Note: The information collected on this form will be used for contact tracing and to determine whether you may be infected with COVID-19. The information on this form will be maintained as confidential.