Worship Date_____

Name_____**. Household number**_____

Names of people in the household_____

_____

Phone Number_____

Email_____

COVID SCREENING QUESTIONS

Yes	No	Question
		Have you or anyone in your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever at or greater than 100 degrees Fahrenheit?
		Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19?
		Are you or anyone in your household a health care provider or emergency responder?
		Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19?