COVID-19 Health Screening Questionnaire

One form per household. Please enter temperature reading for each person who is entering.

Date	**Reason for entering Church**
Name	**Temperature**
Email Address	**Phone**

COVID-19 Symptoms:

Fever or chills
Cough
Sore throat
Congestion or runny nose
Congestion or runny nose
Nausea or vomiting
Diarrhea
Shortness of breath
Fatigue
Headache
Muscle or body aches
New loss of taste or smell

Have you or anyone in your household experienced any symptoms of or tested positive for COVID-19 in the past 14 days?

☐ **Yes** ☐ **No**

Have you or anyone in your household knowingly been in close or proximate contact in the past 14 days with anyone who has tested positive for COVID-19 or anyone who has had symptoms of COVID-19?

☐ **Yes** ☐ **No**

Enter Additional Family Members below:

Name	**Temp**	**Name**	**Temp**