FAITH FORMATION COVID-19 SCREENING FORM

Name:_____ Date:_____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS IN THE PAST 48 HOURS:

- Fever or Chills,
- cough,
- shortness of breath or difficulty breathing,
- fatigue,
- muscle or body aches,
- headache,
- new loss of taste or smell,
- sore throat,
- congestion or runny nose,
- nausea or vomiting,
- diarrhea

☐ Yes

☐ No

☐ Other

If you have experienced any of the above symptoms in the past 48 hours, **DO NOT VOLLUNTEER.** Stay home until your symptoms subside for more than 48 hours. If you have a chronic medical condition that causes Covid-19-like symptoms, then check the *Other* box.

HAVE YOU BEEN IN CLOSE PHYICAL CONTACT, IN THE LAST 14 DAYS, WITH: ANYONE WHO IS KNOWN TO HAVE LABORATORY CONFIRMED COVID-19? AND WERE YOU WITHIN SIX FEET FOR LONGER THAN 15 MINUTES? OR CLOSE PHYICAL CONTACT WITH ANYONE WHO HAS SYMPTOMS CONSISTANT WITH COVID-19?

☐ Yes

☐ No

Close physical contact is defined as being within 6 feet of an infected or symptomatic person for a cumulative total of 15 minutes or more over a 24-hour period starting from 48 hours before illness onset.

DO YOU HAVE A TEMPERATURE OF 100.4 OR GREATER?

☐ Yes

☐ No

I certify that my responses are true and correct ☐ Yes ☐ No

Signature: _____