Member_____

Visitor _____

Temp _____

Burns Seventh-day Adventist Church

COVID-19 Medical Screening

Church Entrance Questionnaire

DATE_____

NAME_____

PHONE # _____

In the last 14 days have **YOU** or **ANYONE YOU LIVE WITH** or **COME IN CONTACT WITH** experienced:

1. fever, chills, muscle aches? YES NO
2. a sore throat, cough, pain with difficulty breathing, or bloody sputum? YES NO
3. any nausea, vomiting or diarrhea? YES NO
4. a headache or loss of taste or smell? YES NO

In the last 14 days have **YOU** or **ANYONE YOU LIVE WITH** or **COME IN CONTACT WITH** experienced:

1. fever, chills, muscle aches?
2. a sore throat, cough, pain with difficulty breathing, or bloody sputum?
3. any nausea, vomiting or diarrhea?
4. a headache or loss of taste or smell?