

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Temperature: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_**

**Event: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Do you have any of the following COVID-19 related symptons? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_**

**(Circle all that apply)**

**Fever or chills Loss of taste or smell**

**Cough Sore throat**

**Shortness of breath or difficulty breathing Congestion or runny nose**

**Fatigue Nausea or Vomiting**

**Muscle or Body Aches Diarrhea**

**Headaches**

1. **Have you knowingly been exposed to anyone who has tested positive for COVID-19 in the last 14 days? Yes\_\_\_\_ No \_\_\_\_\_**
2. **Have you received a positive COVID test result within the last 14 days? Yes \_\_\_\_\_ No \_\_\_\_\_\_**
3. **Are you currently awaiting COVID-19 test results? Yes \_\_\_\_\_ No \_\_\_\_\_\_**

**Signature of Attendee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Church Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**