Springfield Baptist Church COVID-19 Assessment

 Name: Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Event: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Temp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Temp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any of the following COVID-19 related symptoms? \_\_ Yes \_\_\_No
* 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
1. Have you knowingly been exposed to anyone who has tested positive for COVID-19?
* Yes
* No
1. Have you received a positive COVID test result within the last 14 days?
* Yes
* No
1. Are you currently awaiting COVID-19 test results?
* Yes
* No

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Event Attendee Signature Date

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Springfield Baptist Church Representative Date