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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Event Attendee Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Springfield Baptist Church Representative Date