

Entry to Parish Center Questionnaire

Employee Name: _____ Today's Date: _____

Date Last Entered the Facility: _____

In the last 14 days.....

1. Have you had a fever greater than 100.4 degrees Fahrenheit? Yes ___ No ___
2. Have you experienced abnormal coughing? Yes ___ No ___
3. Have you experienced shortness of breath or difficulty breathing?
Yes ___ No ___
4. Have you had chills or repeated shaking with chills? Yes ___ No ___
5. Have you had any unusual or aggravated muscle pain? Yes ___ No ___
6. Have you had a headache that is not alleviated by typical pain
killers (acetaminophen, ibuprofen, aspirin, etc.)? Yes ___ No ___
7. Have you had a nagging sore throat? Yes ___ No ___
8. Have you experienced loss of taste or smell? Yes ___ No ___
9. Have you been in close proximity or in contact with someone
who exhibits symptoms or been diagnosed with COVID-19? Yes ___ No ___
10. Have you traveled to or been in direct contact with anyone
who has traveled to any of the following states or territories
within the last 14 days? AL, AK, AR, AZ, CA, DE, DC, FL, GA,
IA, ID, IL, IN, KS, KY, LA, MN, MS, MO, MT, NE, NV, NM, NC, ND,
OH, OK, PR, SC, TN, TX, VA, WA, WI Yes ___ No ___
11. Have you traveled to or been in direct contact with anyone
who has traveled internationally? Yes ___ No ___