Entry to Sunday School Screening Questionnaire

Student Name: _____ Today's Date: _____

Temperature: _____

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 ____