



Dr. Eric Jackson, Senior Pastor • Kenneth Baines, Deacon Ministry Chair • Barbara Wells, Trustee Ministry Chair

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## COVID-19 Screening Questionnaire

**Have you had any of these symptoms within the past 48 hours?**

1. Do you have any of the following symptoms?
  - a. Fever of 100.0F or greater
  - b. Cough – New onset
  - c. Shortness of breath
  - d. Chills
  - e. Muscle pains
  - f. New rash on fingers or toes
  - g. Sore throat
  - h. New loss of taste or smell
  - i. Vomiting or diarrhea
  - j. Unusual fatigue
  - k. No Symptoms
  
2. Have you been in contact with a known positive COVID-19 individual in the last 14 days?      a. Yes                      b. No
  
3. Have you been told by a healthcare provider to quarantine in the last 14 days?                      a. Yes                      b. No

**PLEASE PRINT NAME & SIGN:**

Print Name \_\_\_\_\_ Sign \_\_\_\_\_

Date \_\_\_\_\_ Phone \_\_\_\_\_

Email Address: \_\_\_\_\_