In-Person Worship/ Health Assessment Form

Please print. Hand-in at entrance to sanctuary. For health screening and contract tracing purposes only. Thank you.

Name _____

Worship Date _____

Phone number _____

Vaccinated?

YES

NO

Have you been experiencing any of the following: shortness of breath, cough, fever, chills, body aches, loss of sense of smell or taste, headache, nausea, or vomiting?

YES

NO

In the last 14 days, have you been within 6 feet for 15 minutes or more with anyone that has tested positive for COVID-19?

YES

NO

Have you been tested, with a positive result, for COVID-19?

YES

NO