

Print Name: _____ Date: _____ Temp. _____

COVID-19 HEALTH QUESTIONNAIRE for FIRST PRESBYTERIAN

Please review and answer the questions below. A completed health form will be required from you **each time** you enter First Presbyterian for worship, a meeting or other in-person activity.

If you are in any of the 'high risk' categories defined by the CDC, we urge you to consider attending the meeting virtually (online) or by telephone rather than entering the building.

Have you been vaccinated? Y ___ N ___. **If no, please answer the following questions:**

1. Have you or anyone in your household tested positive for COVID-19 (within the last 14 days) or is awaiting results of a COVID-19 test? N ___ Y ___ If you tested positive, you must wait 10 days after becoming symptom- free or have received a negative result from 2 subsequent COVID-19 tests in a row at least 24 hours apart.

2. Do you or anyone in your household have any of the following symptoms?
 - a. Fever over 100.4 degrees N ___ Y ___
 - b. Cough N ___ Y ___
 - c. Sore throat N ___ Y ___
 - d. Headache N ___ Y ___
 - e. Nasal congestion or runny nose N ___ Y ___
 - f. Shortness of breath or difficulty breathing N ___ Y ___
 - g. Fatigue; unexplained muscle or body aches N ___ Y ___
 - h. Loss of taste or smell N ___ Y ___
 - i. Nausea, vomiting, or diarrhea N ___ Y ___
 - j. Repeated shaking with chills N ___ Y ___

3. Have you or anyone in your household returned from international travel or from states beyond the tri-state region (NJ, NY, CT) within the past 14 days? N ___ Y ___

4. In the past 14 days, have you or anyone in your household had close contact with someone who has tested positive or has exhibited COVID-19 symptoms as defined above? (Close contact means being within 6 feet for more than 10 minutes). N ___ Y ___

If you answered 'YES' to any of these questions, you may not enter the building today.

Thank you very much for your cooperation.

Signed: _____ phone #: _____

Form Date: 05/10/21