East Berlin Community Church

COVID-19 Pre-screening Questions

Name: _____ Date:_____

Telephone: _____ Temperature: _____

Are you experiencing any of the following symptoms?

1.	Cough (not due to allergies)	Yes	No
2.	Shortness of breath or difficulty breathing	Yes	No
3.	Sore Throat	Yes	No
4.	Chills	Yes	No
5.	Muscle ache or unusual fatigue	Yes	No
6.	Headache	Yes	No
7.	New loss of taste or smell	Yes	No
8.	Abdominal pain, nausea, vomiting, diarrhea	Yes	No

Have you had close contact with someone who has currently tested positive for COVID-19 ?	Yes	No
Have you been diagnosed with COVID-19 in the past three weeks or have reason to believe you have it?	Yes	No
Have you traveled or had close contact with someone who has traveled internationally in the last 14 days?	Yes	No

Signature: _____

East Berlin Community Church

COVID-19 Pre-screening Questions

Name: _____ Date:_____

Telephone: _____ Temperature: _____

Are you experiencing any of the following symptoms?

1.	Cough (not due to allergies)	Yes	No
2.	Shortness of breath or difficulty breathing	Yes	No
3.	Sore Throat	Yes	No
4.	Chills	Yes	No
5.	Muscle ache or unusual fatigue	Yes	No
6.	Headache	Yes	No
7.	New loss of taste or smell	Yes	No
8.	Abdominal pain, nausea, vomiting, diarrhea	Yes	No

Have you had close contact with someone who has currently tested positive for COVID-19 ?	Yes	No
Have you been diagnosed with COVID-19 in the past three weeks or have reason to believe you have it?	Yes	No
Have you traveled or had close contact with someone who has traveled internationally in the last 14 days?	Yes	No

Signature: _____