HEALTH QUESTIONNAIRE

These questions are to screen for people who *could* transmit the virus causing COVID-19. The information will remain confidential and reviewed only by local clergy, the District Superintendent, the Bishop, the Chancellor or the Department of Health for possible contact tracing. **Please return completed form to your local clergy at least 4 days before you plan to attend the service by email. If you don't have email, call your clergy and provide the information below on the telephone.**

1. **TRAVEL**: Have you traveled away from Virginia to another state or outside the country in the past 14 days? Please indicate.

   [ ] Yes [ ] No

   If yes, where did you go? _____

2. **SYMPTOMS**: Please check Yes or No as to whether you are now experiencing, or have experienced during the past **14 DAYS, ANY** of these symptoms:

a.	Fever, feeling hot, or feverish	[ ] Yes	[ ] No
b.	Shortness of breath or difficulty breathing	[ ] Yes	[ ] No
c.	Chills, or repeated shaking with chills	[ ] Yes	[ ] No
d.	Cough	[ ] Yes	[ ] No
e.	Flu-like symptoms, diarrhea, intestinal upset, or fatigue	[ ] Yes	[ ] No
f.	Sore throat	[ ] Yes	[ ] No
g.	Headache	[ ] Yes	[ ] No
h.	Muscle pain	[ ] Yes	[ ] No
i.	Recent loss of taste or smell	[ ] Yes	[ ] No

3. **CONTACT**: Have you been come in contact with someone experiencing symptoms of COVID-19 identified in #2 above **in the past 14 days**? Please indicate.

   [ ] Yes [ ] No

   If yes, please explain who you came in contact with, where you came in contact, and why you came in contact with this person. _____

4. **TESTING**:

a.	I tested positive for COVID-19.	[ ] Yes	[ ] No
b.	I have or had symptoms of COVID-19 and I am waiting for results of COVID-19 testing.	[ ] Yes	[ ] No
c.	If tested for COVID-19, I agree to provide the results of my test to my clergy, DS, and Bishop.	[ ] Yes	[ ] No

5. **AFTER SERVICE HEALTH CHANGE**: If I develop 2 or more of the common symptoms of COVID-19 listed above after attending an In-Person service, I will immediately contact my local clergy and I will avoid contact with others and seek immediate medical attention.

   [ ] Yes [ ] No

Acknowledged and Agreed: [Print Name}_____ _____ ___, 2020

_____ Phone Number: _____ Email: _____

[Sign Name Here]