Health Assessment

Printed Name ____

In the past 24 hours, have you or a member of your household experienced:

1. Subjective Fever (felt feverish) Yes ____ No ____
2. New or Worsening Cough Yes____ No____
3. Shortness of Breath Yes ____ No ____
4. Sore Throat Yes ____ No ____
5. Diarrhea Yes ____ No ____
6. Current Temperature ________°F

If you answered "yes" to any of the symptoms listed above or if your temperature is 100°F or higher, please do not attend the meeting. It is recommended that you "self-isolate" at home and contact your primary physician's office IMMEDIATELY for directions.

In the past 14 days, have you or a member of your household:

1. Had close contact with an individual diagnosed with COVID-19, serious respiratory illness, or other communicable disease? Yes ____ No ____
2. Traveled internationally or domestically where positive testing rates are 15% or higher? Yes ____ No ____

If you answered "yes" to either of these questions, please do not attend the meeting. It is recommended that you self-quarantine at home for 14 days.

*To save time please complete this form and bring it to the meeting. If you do not have a completed form when you arrive you will be required to complete one before you can be admitted.

MASKS ARE REQUIRED TO BE WORN UPON ENTERING THE BUILDING

TEMPERATURE TAKEN AT CHECK IN:

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Signature Date

FORM REVISED 14 Jan 2021