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 by email to your local clergy at least 4 days before you plan to attend the service. If you don't have email, call your clergy and provide the information below on the telephone.**

1.	TRAVEL : Have you traveled away from your regular living area (many members live in neighboring states and commute into Virginia—that does not count as travel to another state) to another state or outside the country in the past 14 days? Please indicate.				
			[] Yes	[] No	
	If yes, where did you g	o?			
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 [] 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 [] Yes [] Yes	[] No	
	g. Headache		[] Yes	[] No	
	h. Muscle pain		[] Yes	[] No	
	i. Recent loss of taste or smell		[] Yes	[] No	
		ho you came in contact with, where y			me in contact
4.	TESTING:				
	a. I tested positive for COVID-19.b. I have or had symptoms of COVID-19 and		[] Yes		
	I am waiting for results of COVID-19 testing. c. If tested for COVID-19, I agree to provide the		[]Yes		
	results of my test to my clergy, DS, and Bishop.		[] Yes	[] No	
5.	listed above after attend	EALTH CHANGE: If I develop 2 of ding an In-Person service, I will immake seek immediate medical attention.	nediately contact	my local clergy and	
			[] Yes	[] No	
Acknowledged and Agreed:		[Print Name}			, 2020
		Phone Number	Email:		
[Sign	Name Here]				