COVID-19 Screening Questionnaire

If you answer YES to any of these questions, do not enter the cathedral. Please go home and check with your primary care provider for further instructions, including information about COVID-19 testing.

PLEASE READ EACH QUESTION CAREFULLY	**CIRCLE THE ANSWER THAT APPLIES TO YOU**	
Have you experienced any of the following in the past 48 hours: • fever or chills • cough • shortness of breath or difficulty breathing • fatigue • muscle or body aches • headache • new loss of taste or small • sore throat • congestion or runny nose • nausea or vomiting • diarrhea	Yes	No
Within the past 14 days, have you been in close physical contact (6 feet or closer for a cumulative total of 15 minutes) with: • Anyone who is known to have laboratory-confirmed COVID-19? OR • Anyone who has any symptoms consistent with COVID-19?	Yes	No
Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	Yes	No
Are you currently waiting on the results of a COVID-19 test because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	Yes	No

Name (please print):_____

Signature:_____

Date:_____

Phone:_____

Email:_____