

TODAY'S DATE: _____

Temple Lutheran Church Facilities COVID-19 SCREENING



PLEASE READ EACH QUESTION CAREFULLY		PLEASE CIRCLE THE ANSWER THAT APPLIES TO YOU	
Have you experienced any of the following symptoms in the past 48 hours: <ul style="list-style-type: none">• fever or chills• cough• shortness of breath or difficulty breathing• fatigue• muscle or body aches• headache• new loss of taste or smell• 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: <ul style="list-style-type: none">• Anyone who is known to have laboratory-confirmed COVID-19? OR <ul style="list-style-type: none">• 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?		YES	NO
Did you answer NO to ALL QUESTIONS?	Access to TLC facilities APPROVED .		
Did you answer YES to ANY QUESTION?	Access to TLC facilities NOT APPROVED . Please stay home and consider contacting your health care provider.		



[cdc.gov/screening](https://www.cdc.gov/screening)

Thank you for helping us to protect you and our community.