

Friendship Baptist Church

COVID-19

SCREENING QUESTIONNAIRE

The safety of our employees is our overriding priority. As the coronavirus (COVID-19) pandemic continues, we are monitoring the situation closely and following the guidance from the Centers for Disease Control and Prevention and local health authorities. In order to prevent the spread of the coronavirus and reduce the potential risk of exposure to our workforce, we are asking everyone to complete and submit this questionnaire prior to entering the worksite. Please do not enter the worksite until your responses have been reviewed and your entry has been approved.

Please respond to each of the following questions truthfully and to the best of your ability. Your participation is important to help us take precautionary measures to protect you and our other employees.

- Name: (please print) _____
- Phone Number (mobile/home): _____
- Ministry of the church you serve: _____

- **QUESTIONS:**

1. Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms? (Please take your temperature before you answer this question.)
 - a. Yes No Fever (100.4° F/37.8° C or greater as measured by an oral thermometer)
 - b. Yes No Cough
 - c. Yes No Shortness of breath or difficulty breathing
 - d. Yes No Sore throat
 - e. Yes No New loss of taste or smell
 - f. Yes No Chills
 - g. Yes No Head or muscle aches
 - h. Yes No Nausea, diarrhea, vomiting
2. In the past 14 days, have you been in close proximity to anyone who was experiencing any of the above symptoms or has experienced any of the above symptoms since your contact?
Yes No
3. In the past 14 days, have you been in close proximity to anyone who has tested positive for COVID-19? Yes No
4. Have you been tested for COVID-19 and are waiting to receive test results?
Yes No -

5. Have you have tested positive for COVID-19, or are you presumptively positive for COVID-19 based on your health care provider's assessment or your symptoms?
Yes No

NOTE: If you have tested positive for COVID-19 or have been presumptively positive for COVID-19 based on your health care provider's assessment or your symptoms, please contact your Overseer or General Overseer, in that order when: (1) you have had no fever for at least 72 hours (3 full days), without the use of fever-reducing medications; (2) your other symptoms have improved; and at least 7 days have elapsed since your symptoms first appeared.

6. In the past 14 days, have you been on a commercial flight or traveled outside of the United States? Yes No
7. In the past 14 days, have you been in close proximity to anyone who has been on a commercial flight or traveled outside of the United States? Yes No
8. Is there any reason why you feel you are at higher risk of contracting COVID-19 or experiencing complications from COVID-19 by entering the facility? If "yes", please provide a brief explanation.
Yes No

Explanation: _____.

Certification

I hereby certify that the responses provided above are true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Note: The information collected on this form will be used to determine only whether you may be infected with COVID-19. The information on this form will be maintained as confidential. Any questions should be directed to your Overseer or General Overseer in that order.