



SALEM ASSEMBLY OF GOD COVID -19 SCREENING QUESTIONS

1. In the last 14 days, did you receive a confirmed diagnosis of COVID-19 by a healthcare professional or are you waiting for a pending COVID-19 test result?
☐ Yes ☐ No
2. In the last 14 days, have you had close contact with or cared for someone currently diagnosed with COVID-19?
☐ Yes ☐ No
3. In the last 14 days, have you experienced any flu-like symptoms including (but not limited to) fever, cough, shortness of breath, sore throat, chills, loss of smell or taste? (NOTE: "Yes" if worse than what you normally experience, "No" if common issue cleared by health professional)
☐ Yes ☐ No
4. In the last 14 days, have you traveled domestically or internationally (except commuting between work/home by personal vehicle)?
☐ Yes ☐ No

a. If yes to question 4, where and how (ex. plane, bus, ferry)

☐ I certify the above information is true and release Salem Assembly of God from any and all liability for unintentional exposure or harm due to COVID-19

X _____
(sign name)

(print name)