Providence Presbyterian Church
COVID-19 Wellness Form

1. Are you experiencing any of the following symptoms today? (that you cannot attribute to another health condition).

Fever	___ Yes ___ No		Cough	___ Yes ___ No	
Sore Throat	___ Yes ___ No		Difficulty Breathing	___ Yes ___ No	
Muscle Ache	___ Yes ___ No		Chills	___ Yes ___ No	
Shortness of Breath	___ Yes ___ No				

2. Have you experienced any cold or flu-like symptoms in the last 14 days (to include fever, cough, sore throat, respiratory illness, loss of smell or taste, and/or difficulty breathing)?

___ Yes ___ No

3. Have you returned from any international or domestic travel within the last 14 days?

___ Yes ___ No

4. Have you been in close contact with anyone who has traveled internationally or domestically within the last 14 days?

___ Yes ___ No

5. Have you had close contact with or cared for someone diagnosed with COVID-19 within the last 14 days?

___ Yes ___ No

I attest that I/we have measured my body temperature today. Furthermore, if I/we have answered "yes" to Question 1 or 2, I certify that I will seek immediate medical diagnosis from a qualified healthcare professional and inform Providence immediately of the results. If I am on staff at Providence, I will provide documentation of any diagnosis and treatment - specifically any diagnosis of COVID-19 and follow-on treatment - to the Session.

If I/we have answered "yes" to any Question 1 through 5, or if my/our temperature exceed 100.4 degrees, I/we will not attend worship at Providence Presbyterian.

_____	_____	_____
Print Name	Signature	Date
_____	_____	_____
Print Name	Signature	Date
_____	_____	_____
Print Name	Signature	Date