PLEASE DO NOT ATTEND CHURCH SERVICES OR ACTIVITIES IF YOU HAVE ANSWERED "YES" TO ANY OF THE FOLLOWING QUESTIONS!

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 air, train, or bus travel within the last 14 days?**

   ___Yes ___No

4. **Have you been in close contact with anyone who has traveled internationally or domestically by air, train, or bus 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

6. **I checked my body temperature this morning and it was 100 degrees Fahrenheit or more.**

   ___Yes ___No

I/we attest that if I/we have answered yes to any of the above questions, I/we will not attend worship service today and will seek immediate medical diagnosis from a qualified healthcare professional. Should I show symptoms and be tested for COVID-19 after attending a service, I will immediately notify the church. If I am on staff at Providence, I will provide documentation of any COVID-19 diagnosis and treatment to the Session.

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