Alumni Activities COVID-19 SYMPTOM/RISK QUESTIONNAIRE

Name _____ will be screened by guardian on the questions below before attending each and every alumni event and will not attend DGE Night School and/or Socials if the answer is yes to any of the questions below.

_____ _____

Signature **Date**

Please sign and return this form to Mr. Killian at jkillian@eclcofnj.org or by faxing to 973-701-1059 before attending the first event. (we only need this form submitted once)

NAME:		
1. In the past 24 hours, have you had any symptoms of fever such as chills, sweats, felt "feverish" or had a temperature of 100.4 degrees or higher?	YES	NO
2. In the past 24 hours, have you taken medicine to reduce fever?	YES	NO
3. Do you have any of these symptoms?		
Cough	YES	NO
Shortness of breath/difficulty breathing	YES	NO
Loss of taste or smell	YES	NO
Fever/chills/sweats	YES	NO
Body aches	YES	NO
Sore throat	YES	NO
Headache	YES	NO
Diarrhea	YES	NO
Nausea/vomiting	YES	NO
Nasal congestion/runny nose	YES	NO
4. In the past 14 days, have you travelled out of the country?	YES	NO