**HEALTH QUESTIONNAIRE AND ACKNOWLEDGMENT FORM--ARIZONA**

 These questions are to screen for people who *could* transmit the virus causing COVID-19. The information will remain confidential and be reviewed only by the program administrators or the Department of Health for possible contact tracing. **Please return the completed form to the church administrators at least \_\_ days before you attend church.**

1. **TRAVEL**: Have you traveled away from Arizona to another state or outside the country in the past 14 days? Please indicate.

[ ] Yes [ ] No

If yes, where did you go? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **SYMPTOMS**: Please check Yes or No as to whether you are now experiencing, or have experienced during the past **14 DAYS, ANY** of these symptoms:
	1. Fever, feeling hot, or feverish [ ] Yes [ ] No
	2. Shortness of breath or difficulty breathing [ ] Yes [ ] No
	3. Fatigue [ ] Yes [ ] No
	4. Cough [ ] Yes [ ] No
	5. Sore throat [ ] Yes [ ] No
	6. Congestion or runny nose [ ] Yes [ ] No
	7. Headache [ ] Yes [ ] No
	8. Muscle or body aches [ ] Yes [ ] No
	9. Recent loss of taste or smell [ ] Yes [ ] No
	10. Nausea or vomiting [ ] Yes [ ] No
	11. Diarrhea [ ] Yes [ ] No
2. **CONTACT**: Have you come in contact with someone experiencing symptoms of COVID-19 identified in #2 above **in the past 14 days**? Please indicate.

[ ] Yes [ ] No

If yes, please explain who you came in contact with, where you came in contact, and why you came in contact with this person. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **TESTING**:
	1. I tested positive for COVID-19. [ ] Yes [ ] No
	2. I have or had symptoms of COVID-19, and

am waiting for results of COVID-19 testing. [ ] Yes [ ] No

* 1. If tested for COVID-19, I agree to provide the

results of my tests to church administrators. [ ] Yes [ ] No

1. **AFTER-SERVICE HEALTH CHANGE**: I understand that if I develop 2 or more of the common symptoms of COVID-19 listed above, I will immediately contact church administrators in writing to update this form, I will ensure I avoid contact with others, and I will seek immediate medical attention.

**Acknowledged and Agreed:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_, 2020

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_