COVID-19 Screening Questionnaire

Your Childs Name:			
Location:	St. Maria Goretti Parish		
City:	Hatfield, PA		
Activity:	Parish Religious Education	Date:	

	Yes	No
1. Have you or your child had a temperature at or over 100.4 F? Register your child's temperature here:	_____	_____
2. Within the last fourteen (14) days, have you or your child tested positive for COVID- 19? *If No, then continue.*	_____	_____
3. Within the last fourteen (14) days, have you or your child had direct contact with a person confirmed or suspected to have COVID-19? *If No, then continue.*		_____
4. Within the last fourteen (14) days, have you or your child been asked to self- quarantine? *If No, then continue.*	_____	_____
5. Within the last fourteen (14) days, have you or your child had any cold or flu-like symptoms such as fever, cough, shortness of breath, difficulty breathing, sore throat, body aches, or lack of taste or smell? *If No, then continue.*	_____	_____
6. Within the last fourteen (14) days, are you aware of you or your child being in contact with someone with cold or flu-like symptoms such as fever, cough, shortness of breath, difficulty breathing, sore throat, body aches, or lack of taste or smell? *If No, then continue.*	_____	_____
7. Within the last fourteen (14) days, have you or your child traveled to a place with rising community transmission of COVID-19? *If No, then continue.*	_____	_____
8. Within the last fourteen (14) days, have you traveled on an airplane?	_____	_____

Parent/Guardian
Signiture:_____