Youth Group Covid-19 Health Screening Form

Full Name

Date

Parent/Guardian Name

Contact Number

Email Address

Symptoms Check (In the last 24 hours, have you experienced any of the following?)

☐ Fever or chills ☐ Cough ☐ Shortness of breath or difficulty breathing ☐ Sore throat

☐ Loss of taste or smell ☐ Muscle or body aches ☐ Other symptoms

In the past 10 days, have you:

Tested positive for Covid-19?

○ Yes ○ No

Been in close contact with anyone diagnosed with Covid-19?

○ Yes ○ No

Traveled outside the country or to a high-risk area?

○ Yes ○ No

Signature

Youth/Parent/Guardian Signature

Signature Date