

| Southside Church COVID-19 Health Screening Checklist | | |
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| Instructions: | | |
| Part I | | |
| Yes | No | |
| | | In the last 14 days, have you tested positive due COVID-19 OR are waiting on test results for COVID-19 due to exhibiting symptoms? |
| Within the last 72 hours have you, or a person you have CLOSE* daily contact | | |
| | | Fever (100.4oF) or higher? |
| | | Deep Persistent Cough (respiratory aggravation / distress)? |
| | | Difficulty breathing (feeling “winded”; struggling to draw in full breath)? |
| | | New loss of taste or smell not attributed to other medical condition (allergies, cold)? |
| If you answered YES to ANY question PLEASE DO NOT ATTEND service and | | |
| Part II | | |
| Yes | No | |
| | | In the last 14 days, to the best of your knowledge, have you had CLOSE* contact with someone who tested positive for COVID-19? |
| | | In the last 14 days, to the best of your knowledge, have you had CLOSE* contact with someone who has been tested for COVID-19, the test results are not yet available, and the person had the symptoms of Part I at the time of the contact? |
| If you answered YES to ANY question PLEASE DO NOT ATTEND service and | | |
| <p>*CLOSE contact: Being within approximately 6 feet (2 meters) of a COVID-19 case for prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case OR having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on).</p> | | |