Ben Washington Baptist Church

# COVID-19 (Coronavirus) Entry Check List

| Name: | Date of Birth: ____/____/_____ | Phone: ( _____) _____ |
|---|---|---|

In the last 2 weeks, have you had any of the following symptoms?

___ * Fever > 99.5F or Chills

___ * Cough

___ * Lost Ability to Taste or Smell

___ * Headache

___ * Sore Throat

___ * Shortness of Breath

___ * Diarrhea

___ * Body Aches

___ Travel in the last 2 weeks outside of DFW? Where: _____

___ Exposure to someone with confirmed COVID-19 or Coronavirus symptoms listed above in the last 2 weeks for more than 15 minutes.

___ Tested for COVID-19 (Coronavirus) in the last 2 weeks. If so, what were the results of the test: ___ Positive ___ Negative ___ Pending

If any of the (*) are checked we ask that you postpone your visit at this time. We encourage that you seek medical treatment or advice from your physician.

**Current Temperature: _____**

## Protocol while on BWBC premises:

- Please wear your mask/ facial covering.
- Please wash your hands frequently.
- Please keep 6 feet social distance.
- Please stay home if you feel ill and seek medical advice.

Screened by: _____

Date: _____