

Congregation B'nai Tzedek COVID-19 Entry Screening

Member/Guest Name: _____ Arrival Date and Time: _____

In the past 24 hours, have you experienced any of the following new symptoms? (circle your answer)

Fever or Felt Feverish	Yes	No
Sore Throat	Yes	No
Chills (with or without repeated shaking)	Yes	No
Shortness of Breath	Yes	No
Cough	Yes	No
Headache	Yes	No
Muscle pain	Yes	No
Unusual Fatigue	Yes	No
New loss of taste or smell	Yes	No
GI Issues (loose stool, diarrhea)	Yes	No

In the last 14 days have you:

1. Been in close contact with someone who has been diagnosed with or under testing for COVID-19?

____ yes ____ no

2. Traveled outside of the state (You may have to quarantine depending on which state)?

____ yes ____ no

3. Attended a gathering of 50 or more people?

____ yes ____ no

Temperature at arrival: _____ (in Fahrenheit)

If any of the questions are answered "yes," or the temperature reads above 100.3 degrees Fahrenheit, **the member/guest will not be allowed access and asked not to return until they are able to answer no to all the questions and their temperature is in the appropriate range.**

Screening Completed By: _____ (print) Date: _____