**This document will be presented to participants on the date of our live service.**

Tacoma Buddhist Temple

Covid-19 Health Screening

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information will be retained for 2 weeks, then destroyed. Information will be used for contact tracing, if necessary.

**For the health of all those in attendance, please answer the following questions. We appreciate your honesty and concern for all.**

If you answer **Yes** to any question, please do not attend today’s service.

* Are you experiencing any of the following symptoms today or within the last 3 days:

Fever over 100.4

Shortness of Breath, difficulty breathing

Sudden loss of taste or smell

Cough

Chills

Sore Throat

Body ac he

□ Yes □ No

* In the last 10 days, have you been exposed or had close contact with someone with confirmed or suspected COVID-19?

□ Yes □ No

* In the last 10 days, have you tested positive for COVID-19

□ Yes □ No