COVID Screening

Full Name: _____ Phone: _____

Chapter: _____ Date screening was completed: _____

1. Have you or any member of your household been in contact with anyone that has tested positive for COVID in the last 10 days?

☐ No ☐ Yes

2. In the past 10 days, have you or any member of your household traveled to/from an area that the U.S or State Government or Department of Defense mandate a self-quarantine period?

☐ No ☐ Yes

3. Are you or any member of your household currently experiencing flu like symptoms?

☐ • Fever (equal to or over 100.4°F)

☐ • Cough

☐ • Muscle or body ache

☐ • Headache

☐ • Sore throat

☐ • Congestion or runny rose

4. Have you or any member of your household isolating or quarantining because you tested positive for COVID ?

☐ No ☐ Yes

5. Have you been diagnosed with COVID and pending release from isolation by your Medical Provider?

☐ No ☐ Yes

6. Have you received the COVID vaccine?

☐ Yes ☐ No How Many? ☐

I certify that my responses are true and correct.

Type Name Here → _____

NOTE: Please be advised that attendance at all meeting is voluntary. All chapters, return all completed forms to phgchawaii@aol.com no later than 72 hours after the meeting concludes.