



CATHOLIC MISSION TRIPS INC.
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HEALTH SCREENING QUESTIONNAIRE

- Have you received a COVID-19 Vaccine? ____ Y/N
- 1st Dose Date ___/___/___
- 2nd Dose Date ___/___/___
- In the past 3 days, have you received a negative COVID-19 Test? ____ Y/N
- If so, when?_____ (MM/DD/YY)
- Have you been tested positive for COVID-19? ____ Y/N
- If so, when?_____ (MM/DD/YY)

Have you experienced the following symptoms in the past 14 days? Write Y or N.

fever	chills	cough	shortness of breath	difficulty breathing	fatigue	muscle or body aches	headache	new loss of taste or smell	sore throat	congestion or runny nose	nausea or vomiting	diarrhea

Have you been in contact with anyone who has tested positive with COVID-19 in the past 14 days? ____ Y/N

Has anyone in your immediate household experienced the following symptoms in the past 14 days? Write Y or N.

fever	chills	cough	shortness of breath	difficulty breathing	fatigue	muscle or body aches	headache	new loss of taste or smell	sore throat	congestion or runny nose	nausea or vomiting	diarrhea

First Name _____ Last Name _____

Signature _____ Date _____

Parent signature _____ Date _____
 (if under 18)