**CATHOLIC MISSION TRIPS INC.**
**43508 POSTRAIL SQ.**
**ASHBURN, VA 20147**
www.catholicmissiontrips.net

# 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)