ANCHOR CHURCH
PALOS

SELF-CHECK HEALTH CHECK

Please answer the following questions by circling Yes or No.

	FIRST NAME, LAST NAME	ADDITIONAL FAMILY MEMBER NAME	ADDITIONAL FAMILY MEMBER NAME	ADDITIONAL FAMILY MEMBER NAME	ADDITIONAL FAMILY MEMBER NAME	ADDITIONAL FAMILY MEMBER NAME
1. In the past 10 days have you had a fever, cough, congestion, shortness of breath, sore throat, diarrhea, vomiting, body aches, or loss taste/smell?	No Yes	No Yes	No Yes	No Yes	No Yes	No Yes
2. Have you tested positive for COVID-19 in the past 10 days?	No Yes	No Yes	No Yes	No Yes	No Yes	No Yes
3. In the past 10 days have you been in "close contact" with anyone who has a suspected or confirmed COVID-19 diagnosis?	No Yes	No Yes	No Yes	No Yes	No Yes	No Yes
If you answered yes to questions #1 or #2 for any household member, that household member should remain home. If you answered yes to question #3 for any household member, that household member should remain home unless they meet one of the following criteria. Please check any that apply.						
1. I have recovered from COVID-19 within the past 90 days	☐	☐	☐	☐	☐	☐
2. I have been fully vaccinated against COVID-19	☐	☐	☐	☐	☐	☐
3. I have tested positive for COVID-19 antibodies within the past 90 days	☐	☐	☐	☐	☐	☐

"Close Contact" as defined by the CDC includes any of the following:
- You were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more.
- You provided care at home to someone who is sick with COVID-19.
- You had direct physical contact with the person (hugged or kissed them).
- You shared eating or drinking utensils.
- They sneezed, coughed, or somehow got respiratory droplets on you.

Signature _____ Date _____

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	FIRST NAME, LAST NAME	ADDITIONAL FAMILY MEMBER NAME	ADDITIONAL FAMILY MEMBER NAME	ADDITIONAL FAMILY MEMBER NAME	ADDITIONAL FAMILY MEMBER NAME	ADDITIONAL FAMILY MEMBER NAME
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2. Have you tested positive for COVID-19 in the past 10 days?	No Yes	No Yes	No Yes	No Yes	No Yes	No Yes
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