



COVID-19 SELF-SCREENING CHECKLIST

For the safety of everyone around you as well as for yourself, your family and those living in your home, please answer the following questions:

	Yes	No
1. Have you or anyone in your home tested positive for COVID-19?		
2. Do you have a cough?		
3. Do you have a fever >100.4?		
4. Do you have shortness of breath or difficulty breathing?		
5. Do you have chills?		
6. Do you have repeated shaking with chills?		
7. Do you have unexplained muscle pain?		
8. Do you have a new loss of sense of smell or taste?		
9. Do you have a headache?		
10. Do you have a sore throat?		
11. In the last 14 days, have you been exposed to anyone who has or is suspected to have COVID-19?		

If you or someone in your home can answer yes to questions 1-11, Please DO NOT attend Mass. Contact your Primary Care Physician for their advice.

12. In the past 21 days, have you traveled outside of North or South Carolina?		
13. Do you live in a nursing home or long care facility?		
14. Do you smoke or have chronic lung disease or moderate to severe asthma?		
15. Are you immunocompromised? (Undergoing cancer treatment, history of organ transplant, taking medications that limit your immune response?)		
16. If you have diabetes, do you have trouble controlling your blood sugar?		
17. Are you on dialysis?		
18. Do you have liver disease?		
19. Do you have severe heart disease or congestive heart failure?		
20. Are you 65 years of age or older?		
21. Do you have a BMI > 40?		

If you or anyone in your home can answer yes to questions 12-21, please consider NOT attending Mass until further notice as this puts you in a high risk category.

If you are going to attend Mass, please consider taking your temperature before leaving your house to ensure that you have not developed a fever. If you have a fever, please do not attend Mass and consider contacting your Primary Care Physician for their advice.