St. Michael the Archangel, South Glens Falls, NY

MASS CHECK-IN AND HEALTH CERTIFICATION FORM

Mass Date: _____

Mass Time: □ 4:00 PM Saturday □ 5:30 PM Sunday
□ 8:00 AM Sunday □ 8:30 AM Daily
□ 10:00 AM Sunday

Name: _____

Phone: _____

Email: _____

Total Number of immediate family members attending Mass: _____

HEALTH CERTIFICATION

(Answer for all members of your immediate family attending Mass together

Have you had a fever of at least 100.4°F in the last 14 days?

□ Yes
□ No

Have you had any COVID-19 symptoms in the last 14 days?

Symptoms include, but are not limited to: fever or chills; cough; shortness of breath or difficulty breathing; fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

□ Yes
□ No

Have you had a positive COVID-19 test in the last 14 days?

□ Yes
□ No

Have you had close contact with a confirmed or suspected COVID-19 case in the last 14 days?

□ Yes
□ No

If you checked "YES" to ANY of these questions, please stay home and join us on the livestream! *We hope you feel better soon*!