

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 # of household members including self, attending this 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

Have you travelled from out of state 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!***