MIP COVID-19 Screening Questionnaire

ALPHA KAPPA ALPHA SORORITY, INCORPORATED®
MIP COVID-19 SCREENING QUESTIONNAIRE

This form must be completed before each in-person activity during the Membership Intake Process by ALL PARTICIPANTS.

First Name: Last Name:

Email Address:

Mobile Number: Temperature*:

*Temperature will be taken by the chapter sponsoring the Membership Intake Process prior to entry.

Have you been diagnosed positive with COVID-19 within the last 14 days? Yes No
If YES, please provide clearance documentation.

Have you experienced any of the following symptoms: fever, shortness of breath or difficulty breathing, runny nose, loss of taste or smell, dry cough, sore throat, chills, muscle pain, headache, diarrhea or vomiting? Yes No

Have you been exposed to someone with a suspected and/or confirmed case of COVID-19 within the last 14 days? Yes No
If YES, please provide clearance documentation.

Have you traveled to a highly-impacted area or hot spot within the United States in the last 14 days? Yes No

Have you traveled internationally within the last 14 days? Yes No

Have you failed to follow the CDC-recommended guidelines as much as possible and failed to limit your exposure to COVID-19. Yes No

If participant answers "YES" to any of the questions above, immediately notify the Graduate Advisor or Membership Chairman and await further instructions before permitting entry.

Participant's Signature | Participant's Date of Birth | Date

Reviewer's Signature | Reviewer's Printed Name | Date

Rev. 1/28/2021