Daily Self-Screening

Name of Participant (Please print)**:** ____
Date: __________________

Individuals must self-screen at home prior to coming to the program. This form must be completed and signed by all staff, caregivers, guardians, participants, or any individual seeking entry into the program space.

Today or in the past 24 hours have you or any household member had any of the following symptoms?

- Fever (temperature of 100.0®F or above) **Y N**
- Felt feverish or had chills? **Y N**
- Cough? **Y N**
- Sore throat? **Y N**
- Difficulty breathing? **Y N**
- Abdominal pain? **Y N**
- Unexplained rash? **Y N**
- Fatigue? **Y N**
- Headache? **Y N**
- New loss of smell or taste? **Y N**
- New muscle aches? **Y N**
- Nausea or Vomiting? **Y N**
- Diarrhea? **Y N**
- Have you taken any medication to lower a fever within the last 24 hours? **Y N**
- Have you received a positive test result for COVID-19? **Y N** If **Y,** date of test: _______
- Are you waiting to receive results of a COVID-19 test? **Y N**
- In the past 14 days have you had close contact with a person known to be infected with COVID-19? **Y N**

If you have answered any of these questions with a positive result (**Y**), decline to submit to screening OR arrive to your program symptomatic OR without attestation from you or your family/caregiver/guardian you will be isolated immediately and returned to your residence as promptly as possible. If you test positive or your healthcare provider confirms or believes it is probable you have COVID-19 you must stay home for a minimum of 14 days from the onset of symptoms, AND be fever free for 72 hours without fever reducing medications AND experience a significant reduction of symptoms. Please check with your local board of health where you reside for more guidelines regard discontinuing isolation. Please be aware that all positive cases will be reported to our local board of health in order to receive guidance and provide for contact tracing.

Signature: ________________________________ Print Name: _______________________