

Daily Health & Wellness Check/Participant Screening

To comply with MA guidelines, every day each participant in Quincy Recreation Clinics & Workshops will be screened upon arrival of the program. All information will be documented and filed away each day.

This form MUST BE filled out and handed in at drop off DAILY.

Participant's Name: _____ **Date:** ____/____/2020

1. Today or in the past 24 hours, has the participant or any household members had any of the following symptoms?

- A. Fever (temperature of 100.0°F or above), felt feverish, or had chills? Yes No
- B. Cough? Yes No
- C. Sore throat? Yes No
- D. Difficulty breathing? Yes No
- E. Gastrointestinal symptoms (diarrhea, nausea, vomiting)? Yes No
- F. Fatigue? Yes No
- G. Headache? Yes No
- H. New loss of smell/taste? Yes No
- I. New muscle aches? Yes No
- J. Any other signs of illness? Yes No

2. In the past 14 days, has the participant had close contact with a person known to be infected with the novel coronavirus (COVID-19)? Yes No

I, _____ (parent/caregiver signature), am reporting all responses of the participant accurately. I understand that if any of the above answers are yes, my child will not be allowed to enter the facility and therefore must stay/return home with their parent or caregiver. My child may return to the program after they have been symptom free for 24 hours and if they are ill enough to be seen by a physician have a note of clearance.

----- Staff Use Only -----

Staff Member's Name: _____ Group: _____ Location: _____

Visual inspection: Do you notice any flushed cheeks, rapid breathing or difficulty breathing (without recent physical activity), fatigue, or extreme fussiness? Yes No

Once this form is completed, reviewed, and the participant performs hand hygiene, they are allowed on site*

