WDSRA Participant Health Screening-Fall

This form must be completed and brought to program each time the participant attends. Admittance to the program will not be allowed without completed form. To assist with distancing measures please complete and send with participant into program area to be shown and handed to WDSRA staff member.

Name:_____ Date:_____

☐ No ☐ Yes ***Has the participant experienced a fever of 100.4 or greater in the last 24 hours?***

☐ No ☐ Yes ***Does the participant have a cough, sore throat, shortness of breath or difficulty breathing?***

☐ No ☐ Yes ***Has the participant experienced muscle/body aches, fatigue, headache or chills?***

☐ No ☐ Yes ***Has the participant lost sense of smell or taste?***

☐ No ☐ Yes ***Does the participant have nausea, vomiting or diarrhea?***

☐ No ☐ Yes ***Has the participant tested positive or been exposed to someone who tested positive for COVID within the past 14 days?***

If you answer yes to any of these questions admittance to the program will not be allowed.
If any of these symptoms are suspected during the program- contacts will be called to pick up immediately.

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