JCC COVID-19 DAILY HEALTH SCREENING

***You will be required to fill this out, sign it and hand it in DAILY upon arrival.**

Name _____ Date_____

Have you or anyone in your household, had any of the following since the last time you were here:

1. A fever of 100.0°F or higher or a sense of having a fever? _____
2. A cough that you cannot connect to another health problem? _____
3. Shortness of breath that you cannot connect to another health problem? _____
4. A sore throat that you cannot connect to another health problem? _____
5. Muscle aches that you cannot connect to another health problem or to another activity such as physical exercise? _____
6. Vomiting or diarrhea that you cannot connect to another health problem? _____
7. Has your child or anyone in your household been in close contact with anyone suspected or confirmed with COVID-19? _____
8. Have you or your child had any medication to reduce a fever before coming to the JCC today? _____
9. Have you or anyone in your household traveled internationally or domestically, from an area which is experiencing widespread community transmission of COVID-19? _____
10. Have you or anyone in your household been diagnosed with COVID-19? _____

Signed _____ Date_____