Sheldrake Environmental Center

Health Screening Assessment

Participant Name: _____ **Date: _____**

In an effort to reduce illness at our programs, we ask that you check on the health of your child and complete this form prior to participating in each session of our programs.

Please initial each question, record their temperature and indicate if your child has any symptoms. If symptoms or a temperature are observed, do not bring your child to the program. Please notify your program teacher or the Executive Director of Sheldrake, Jennifer Keefe of your child's symptoms immediately. It is strongly recommended to have your child evaluated by a licensed healthcare provider prior to returning to the program.

Common COVID-19 Symptoms (Check All That Apply)	**Please Initial**
□ Cough □ Shortness of breath or difficulty breathing □ Fever □ Chills □ Muscle pain □ Sore throat □ New loss of taste or smell □ Nausea □ Vomiting □ Diarrhea □ Skin rash □ Redness of eyes □ Loss of appetite □ Fatigue □ Abdominal pain □ Other _____ **Notify DOH within 24 hours if participant has temperature of 100.4°F and at least one additional symptom.**	• My child has not had any COVID-19 symptoms in the past 14 days. **Initial** _____ • My child has not tested positive for COVID-19 in the past 14 days. **Initial** _____ • My child has not had close or proximate contact with confirmed or suspected COVID-19 case in the past 14 days. **Initial** _____

Temperature At Home _____ **Date** _____ **Initial** _____

Parent Signature _____

_____

For Office Use Only

Temperature Check Upon Arrival To Program _____

Received By _____