Rutherford Recreation Fall 2020 Daily Screening

To participate at every session, every participant MUST have a completed Questionnaire

COVID-19 Daily Pre-screening Questions

Name of Participant: _____ Date: _____

Are you experiencing any of the following symptoms?	**Please Circle One**	
1. Fever (≥ 100.4°F)	**YES**	**NO**
2. Cough or shortness of breath	**YES**	**NO**
3. Sore Throat	**YES**	**NO**
4. Chills	**YES**	**NO**
5. Muscle aches or rigors	**YES**	**NO**
6. Headache	**YES**	**NO**
7. New loss of taste or smell	**YES**	**NO**
8. Abdominal pain, nausea, vomiting or diarrhea	**YES**	**NO**
Have you had close contact with someone who is currently sick?	**YES**	**NO**
Have you been diagnosed with COVID-19 in the past three weeks or have reason to believe you have COVID-19?	**YES**	**NO**
Have you traveled to a location that has been identified as high COVID positive rate state or country?	**YES**	**NO**

What was is your current body temperature: _____

If the participant or a family member experience symptoms of COVID-19 within two weeks of any program you MUST contact the Recreation Department 201-460-3015.