

# Participant Health Screening Checklist

For use at events & outings as well as meetings

Name: \_\_\_\_\_ Unit # \_\_\_\_\_ Date: \_\_\_\_\_

*All participants (youth and adult) should use this checklist or similar screening to mitigate possible exposure to communicable diseases. This checklist should be completed twelve hours or less before the start of the activity. It should be collected and reviewed as participants arrive.*

## Part 1: Higher Risk for Serious Illness

If you are at higher risk as defined by CDC guidelines, it may be recommended that you stay home unless you have approval from your health care provider. The CDC describes those at higher risk for severe illness from COVID-19 as those who are / have:

- 65+ years old
- Obesity
- Smoker
- Respiratory issues (lung disease, severe asthma, cystic fibrosis)
- Circulation issues (high blood pressure, coronary disease)
- Diabetes
- Immunosuppression
- Chronic kidney or liver disease

## Part 2: Recent Interactions

- \_\_\_ Yes \_\_\_ No      Do you have COVID-19 or are you currently awaiting results of a COVID-19 Test?
- \_\_\_ Yes \_\_\_ No      Have you been in contact with anyone who has COVID-19 or is ill with a respiratory illness but has not been test for COVID-19 in the last 14 days?
- \_\_\_ Yes \_\_\_ No      Do you (or someone you have been in close contact with) live, work, or travel in an area with a large outbreak of COVID-19 disease (hot spot) in the last 14 days?
- \_\_\_ Yes \_\_\_ No      Are you (or anyone you have been in close contact with) under current advisement by public health authorities to quarantine or self-isolate?

**If any question is answered – YES, the individual should stay home.**

## Part 3: Health Screening

Do you have any of the following symptoms which are related to a new / recent illness and cannot be attributed to another health condition?

- |                |                               |                |                            |
|----------------|-------------------------------|----------------|----------------------------|
| ___ Yes ___ No | Fever or chills               | ___ Yes ___ No | Congestion, runny nose     |
| ___ Yes ___ No | Cough                         | ___ Yes ___ No | New loss of taste or smell |
| ___ Yes ___ No | Shortness of breath           | ___ Yes ___ No | Headache                   |
| ___ Yes ___ No | Fatigue, muscle or body aches | ___ Yes ___ No | Nausea or vomiting         |
| ___ Yes ___ No | Sore throat                   | ___ Yes ___ No | Diarrhea                   |

**If any question is answered – YES,  
the individual should stay home until cleared by a physician.**