

## **Village of Warwick Recreation Daily COVID Screening Form**

Child's Name: \_\_\_\_\_ Program: \_\_\_\_\_

1. Has your child had COVID-19 symptoms in the past 10 days? (The current CDC definitions of symptoms include but are not limited to: fever or chills, persistent cough, shortness of breath or difficulty breathing, extreme fatigue, muscle or body aches, headache, sore throat, new loss of taste or smell, congestion or runny nose, nausea, vomiting, diarrhea, unexplained rash or pinkeye.

Yes \_\_\_\_\_ No \_\_\_\_\_

2. Has your child tested positive for COVID-19 or been presumed positive in the past 10 days?

Yes \_\_\_\_\_ No \_\_\_\_\_

3. Has your child had close contact with someone confirmed or suspected of having COVID-19 in the past 10 days?

Yes \_\_\_\_\_ No \_\_\_\_\_

4. If yes to the previous question, has your child satisfied the requirements for ending isolation/quarantine? (10 day isolation/quarantine, improvement of symptoms, 72 hours fever free without the use of medication)

Yes \_\_\_\_\_ No \_\_\_\_\_

5. Has your child traveled outside of New York State domestically or internationally to a country designated as Level 2 or 3 by the CDC in the past 10 days?

Yes \_\_\_\_\_ No \_\_\_\_\_

6. If you answered yes to the question above, please list the state or country your child visited.

\_\_\_\_\_

**\*\*If your child is not feeling well please keep your child home.\*\***

**Parent's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_