



Daily Health & Wellness Check

To comply with MA guidelines, every day each participant must print, complete, and bring a new copy of this wellness check PRIOR to attending a program. Extra copies will be available at programs, if needed. All responses will be maintained on file.

Participant's Name: _____ Date: ____/____/____

1. Today or in the past 24 hours, has the participant or any household members had any of the following symptoms?

- A. Fever (temperature of 100.0°F or above), felt feverish, or had chills?..... Yes No
- B. Cough? Yes No
- C. Sore throat? Yes No
- D. Difficulty breathing? Yes No
- E. Gastrointestinal Symptoms (Nausea, Diarrhea, vomiting) Yes No
- F. Fatigue? Yes No
- G. Headache? Yes No
- H. New loss of smell/taste? Yes No
- I. New muscle aches? Yes No
- J. Any other signs of illness? Yes No

2. In the past 14 days, has the participant had close contact with a person known to be infected with the novel coronavirus (COVID-19)? Yes No

I, _____ (parent/caregiver signature), am reporting all responses of the participant accurately. I understand that if any of the above answers are yes, my child will not be allowed to enter the facility and therefore must stay/return home with their parent or caregiver.

Signature: _____

Date: _____

NO ENTRY INTO PROGRAM WITHOUT THIS FORM