NCE SOCCER RESIDENTIAL PROGRAMMING

COVID-19 Pre-Event Medical Screening Checklist (Rev 06/15/2021)

Name	:			Unit/Campsite:	Date:				
Review the health status with each youth and adult participant, before departure and upon arrival at the camp or event. <b>Everyone</b> entering a camp or participating in an event must complete this questionnaire.									
	Yes		No	Are you currently ill or have you been ill at any time in the past 14 days?					
	Yes		No	Are you currently in quarantine for COVID-19 exposure or due to	contact tracing?				
	Yes		No	Are you currently waiting for the results of a COVID-19 test					
For <u>unvaccinated</u> individuals: at any time in the past 14 days, have you									
	Yes		No	- been in close contact with anyone known or suspected to have	COVID-19?				
	Yes		No	- been in close contact with anyone who is waiting for results of a	a COVID-19 test?				
	Yes		No	- travelled outside of the United States					

\* CDC definition of "Close Contact": Within 6 feet of someone who has COVID-19 for a cumulative total of 15+ minutes over a 24-hour period; direct physical contact with an infected person (hugged or kissed them); shared eating or drinking utensils; an infected person sneezed or coughed on you. This applies to people even if wearing face masks.

## If the answer is YES to <u>any</u> question above, you should stay home. If the answer is NO to all questions above, proceed to the symptoms below

If you have one or more of the following new or worsening signs or symptoms OR if anyone in your household has any one of the following new or worsening signs or symptoms of possible COVID-19, all <u>unvaccinated</u> people in the household must stay home.

- □ Shortness of breath
- Muscle or body aches
- □ Sore throat
- □ Flu-like symptoms
- □ Fever of 100 F or more
- Loss of taste or smell

- Nausea or vomiting

## **NOTE:** Potential Higher-Risk Individuals

 Yes **No** Are you in a higher-risk category as defined by the CDC, including older adults, people with medical conditions, and those with other individual circumstances?

## If the answer is YES (you are in a higher risk category), we recommend you stay home. If you choose to participate, you should first discuss this with your health care provider.

Yes	No	Have you been vaccinated for COVID-19?	First or only shot:	
			Second shot:	
Yes	No	Do you have recent negative COVID-19 test?	Test Date	



- Cough
  - Chills
  - □ Fatigue
  - Headache
- Diarrhoea