



### Specialized Programs COVID-19 WELLNESS SCREENING FORM

This form should only be used for participants approved for drop off who are unaccompanied by Parent/Guardian/Caregiver.

Dear Parent/Guardian/Caregiver:

Please continue to monitor your participant for symptoms at home, complete and sign a form **DAILY** and send with your participant to program. If any information changes after you have completed this form, please notify staff immediately by calling: 206-510-7077 for adult programs or 206-475-5798 for youth/transition programs.

<b>Site name</b>		<b>Date</b>	
<b>Participant Name</b>			
<b>Parent/Guardian/Caregiver Name</b>			
<b>Parent/Guardian/Caregiver Phone Number</b>			

1. **If your participant has any of the following symptoms, not caused by another condition, they cannot attend program.** *If your participant has not had any of the symptoms on this list, please mark "no" below.*

<input type="checkbox"/> A Cough	<input type="checkbox"/> A fever of 100.4°F or higher or a sense of having a fever
<input type="checkbox"/> Shortness of breath or difficulty breathing	<input type="checkbox"/> Recent onset of loss of taste or smell
<input type="checkbox"/> A Sore Throat	<input type="checkbox"/> Congestion/running nose – not related to seasonal allergies
<input type="checkbox"/> Fever or Chills	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Muscle or Body Aches	<input type="checkbox"/> Nausea/vomiting/diarrhea
<input type="checkbox"/> Headache	

**No. My participant has none of these symptoms.**

1. If you are not fully vaccinated, have you been in close contact with anyone with COVID-19 in the past 14 days? Close contact is being within 6 feet for 15 minutes or more over a 24-hour period with a person; or having direct contact with fluids from a person with COVID-19 with or without wearing a mask (i.e., being coughed or sneezed on).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Has your participant had a positive COVID-19 test for active virus in the past 10 days, or are you awaiting results of a COVID-19 test?	<input type="checkbox"/>	<input type="checkbox"/>
3. Within the past 14 days, has a public health or medical professional told you to monitor, isolate, or quarantine your participant because of concerns about COVID-19 infection?	<input type="checkbox"/>	<input type="checkbox"/>

**Participants are NOT ALLOWED to stay for program if the answer to any of the above questions is "yes."**

Answer "yes" to any question 1-4?	Signature	Date
<input type="checkbox"/> Yes <input type="checkbox"/> No		

\* If your participant is ill, they should stay home. If you have any concerns or questions about your participant's symptoms, we encourage you to seek guidance from a health care provider.

This screening tool is designed to guide safe practices and is not a substitute for medical evaluation.