WALTHAM ATHLETIC CLUB

DAILY SCREENING FORM

THIS FORM NEEDS TO BE FILLED OUT AND RETURNED EACH DAY PRIOR TO ENTERING THE WAC

DATE:________________

Name of Participant:____

Parent Signature:____

Print Name:____

Today or in the past 24 hours, have you or any of your household members had any of the following symptoms?

- FEVER (TEMP OF 100.00 F OR ABOVE), FELT FEVERISH, OR HAD CHILLS?
- COUGH?
- SORE THROAT?
- DIFFICULTY BREATHING?
- GASTROINTESTINAL SYMPTOMS (DIARRHEA, NAUSEA, VOMITING)?
- FATIGUE?
- HEADACHE?
- NEW LOSS OF SMELL OR TASTE?
- NEW MUSCLE ACHES?
- In the past 14 days have you had close contact with a person known to be infected with the novel coronavirus (COVID 19)?

YES ____________ NO ______________________

If you've answered YES to any of the above, entry into the WAC will not be permitted at this time.

We appreciate your understanding and follow through as we all work through these times together.

Thank You.