West Milford Community Services & Recreation
COVID-19 Temperature and Health Screening

Program Name

Participant Name

First Name

Last Name

Has the participant had a fever of 100.4 degrees Fahrenheit or higher in the last 24 hours?

☐ Yes ☐ No

Does the participant have any of the following symptoms?
Fever/Chills, Shortness of breath, Fatigue, Loss of taste or smell, Sore throat, Muscle or body aches, Diarrhea, Congestion or runny nose

☐ Yes ☐ No

Has the participant tested positive for COVID-19 in the last 14 days?

☐ Yes ☐ No

Has the participant been in contact with anyone that has tested positive for COVID-19 within the last 14 days?

☐ Yes ☐ No

Participant Confirmation Signature

_____
Date

Parent/Guardian Confirmation Signature if participant is a minor.

_____
Date