Volunteer/Program Participant Health Screening

Please answer the following questions the day of the meeting/event. If you answer yes to any please do not attend this in-person meeting or event:

1.) Have you knowingly been in close or proximate contact in the past 14 days with anyone who has tested positive for COVID-19 or who has or had symptoms of COVID-19? **Yes** **No**

2.) Have you tested positive for COVID-19 in the past 14 days? **Yes** **No**

3.) Have you experienced any symptoms of COVID-19 in the past 14 days? **Yes** **No**

According to the CDC guidance on "Symptoms of Coronavirus," people with COVID-19 have had a wide range of symptoms reported, ranging from mild symptoms to severe illness. *Symptoms of COVID-19 include, but are not limited to*:

cough	shortness of breath	difficulty breathing	diarrhea
fever	congestion/runny nose	loss of taste or smell	headache
chills	nausea/vomiting	sore throat	muscle pain

4.) Have you returned from travel to a "high COVID-19 infection rate state" as defined by NYS DOH, in the past 14 days? **Yes** **No**

By signing below you are attesting to the accuracy of the answers to the questions above:

If 18 years or Older - Program Participant/Volunteer *(Please Sign)*_____

If Under 18 Years - Guardian to the Program Participant *(Please Sign)* _____

Due to confidentiality regulations, this screening is to be retained by the adult and/or the guardian of the minor involved in the activity after presenting it for check in.

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4-H YOUTH DEVELOPMENT – Schoharie & Otsego Counties 4-H Club Meeting & Activity Safety Plan

Volunteer/Program Participant Health Screening

Please answer the following questions the day of the meeting/event. If you answer yes to any please do not attend this in-person meeting or event:

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2.) Have you tested positive for COVID-19 in the past 14 days? Yes No

3.) Have you experienced any symptoms of COVID-19 in the past 14 days? Yes No

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