



PARTICIPANTS NAME: _____

PROGRAM: _____

1) HAVE YOU BEEN IN CONTACT WITH ANYONE WHO HAS BEEN DIAGNOSED WITH COVID-19 IN THE LAST 14 DAYS? YES _____ NO _____

2) DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

_____ COUGH	_____ CHILLS
_____ SHORTNESS OF BREATH	_____ HEADACHE
_____ FEVER	_____ LOSS OF TASTE OR SMELL
_____ DIARRHEA	_____ SORE THROAT
_____ VOMITING	_____ MUSCLE PAIN

IF PARTICIPANT ANSWERS YES TO ANY OF THE ABOVE QUESTIONS, THEY WILL NOT BE ABLE TO PARTICIPATE. NO PARTICIPANT WILL BE ALLOWED IN EPS UNTIL THEY HAVE 72 HOURS WITHOUT FEVER

THERE ARE RISKS RELATED TO COVID – 19 THAT MAY ARISE FROM PARTICIPATING IN PROGRAMS AT EPS. PATRONS UNDERSTAND THAT AND ASSUME SUCH RISKS BY PARTICIPATING.

Print Name

Date

Participants signature
(Parent/Guardian is participant is under 18)

Date