GREEN MOUNTAIN COUNCIL
PRE-EVENT SCREENING CHECKLIST

All participants are required to submit this form.

Participant Name: _____ Unit Number: _____

Address: _____

Phone: _____ Email: _____

Name of Driver: _____

___No ___Yes In the last 10 days, have you tested positive for COVID-19? In the last 10 days, have you had symptoms that made you think you had COVID-19?

If your answer is "yes" to either question, you must stay home.

___No ___Yes Are you awaiting the results of a COVID-19 test? In the last 14 days, have you been in close contact* with someone who is awaiting the results of a COVID test?

If your answer is "yes" to either question, you must stay home.

___No ___Yes In the last 14 days, have you been in close contact* with anyone who has been confirmed to have COVID-19?

If your answer is "yes," you must answer this question:

Since that contact, have you completed either a 14-day quarantine, or a 7-day quarantine followed by a negative COVID test?

___No ___Yes **If your answer is "no," you must stay home.**

___No ___Yes Are you in a higher-risk category, as defined by the CDC guidelines?

If your answer is "yes," it is recommended that you stay home.

Have you or any of your immediate family had any of the following symptoms in the last 24 hours?

A	No	Yes	
	___	___	Unusual shortness of breath
	___	___	New or worsening cough
	___	___	Fever of 100.4°F or greater, or chills
	___	___	New loss of taste or smell
	___	___	Nausea or vomiting
	___	___	Diarrhea

If your answer is "yes" to <u>any</u> of the symptoms above, you must stay home.

B	No	Yes	
	___	___	Cough
	___	___	Congestion or runny nose
	___	___	Sore throat
	___	___	Muscle or body aches
	___	___	Unexplained extreme fatigue
	___	___	Headache

If your answer is "yes" to <u>any two</u> of the symptoms above, you must stay home.

* The CDC definition of "close contact": a) you were within 6 feet of someone for a cumulative total of 15 minutes or more over a 24-hour period, b) you had direct physical contact (hugged or kissed them), c) you shared eating or drinking utensils, or d) a person sneezed, coughed, or otherwise got respiratory droplets on you.

Signature of Adult Participant or Youth's Parent/Guardian: _____ Date: _____