Day Habilitation  Daily Screening Attestation for COVID-19 Symptoms

All staff, caregivers/guardians, participants, and any individuals seeking entry into The Charles River Center must be directed to self-screen at home, prior to coming to the program for the day. These questions are subject to change based on state, local and CDC guidelines.

Without completion of the daily attestation form, you may not be granted entry into our facility.

Participants or caregivers/guardians must provide verbal attestations daily regarding any household contacts (you or anyone else in your household) with COVID-19, or if they have taken medicine to lower a fever, and provider must maintain log of who was at the program each day.

Have you or anyone in your household taken any medication to reduce symptoms below?
Yes ☐   No ☐

Please check yes or no if you are experiencing any of the following symptoms:

Fever 100.0F or above: YES ☐ NO ☐
Cough: YES ☐ NO ☐
Sore Throat: YES ☐ NO ☐
Difficulty Breathing: YES ☐ NO ☐
Abdominal Pain: YES ☐ NO ☐
Unexplained Rash: YES ☐ NO ☐
Fatigue: YES ☐ NO ☐
Headache: YES ☐ NO ☐
New loss of smell: YES ☐ NO ☐
New loss of taste: YES ☐ NO ☐
New muscle aches: YES ☐ NO ☐
Nausea or vomiting: YES ☐ NO ☐
Diarrhea: YES ☐ NO ☐
Congestion/Runny Nose: YES ☐ NO ☐

Additional questions:

(a) Have you received a positive test result for COVID-19? YES ☐ NO ☐
(b) When was the date of the test? Date: ______________________
(c) Are you waiting to receive results of a COVID-19 test? YES ☐ NO ☐
(d) 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 ☐
(e) In the past 14 days have you, or anyone else in your household traveled outside of the Northeast? YES ☐ NO ☐

Name of State where travel took place: ______________________
Travel Dates: ______________________  ______________________

<table>
<thead>
<tr>
<th>If you are</th>
<th>Then</th>
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<tbody>
<tr>
<td>Experiencing any of the above symptoms</td>
<td>You may not enter our facility. Stay home, contact your primary care physician and your supervisor</td>
</tr>
<tr>
<td>Feeling well</td>
<td>Enter into our facility</td>
</tr>
</tbody>
</table>

Date: ______________________
Name of Participant: ______________________
Signature: ______________________