Strathmore Road 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>
</tr>
</thead>
<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: _______________________