SAMOSET COUNCIL PRE-EVENT SCREENING CHECKLIST

The intent of this checklist is to review with each participant (youth and adult) their current health status both before departure and upon arrival. Unit leaders should collect this form from their Scouts prior to departing. Samoset Council and the Boy Scouts of America encourages anyone who is in a higher-risk category as defined by CDC guidelines to stay home. Should they choose to participate, they must have approval from their health care provider.

All participants are required to submit this form.

Participant Name: _____ Unit Number: _____

Phone: _____ Email: _____

Name of Driver: _____

Section 1

Yes	No	
___	___	Have you or has anyone in your household been in close contact* with anyone who has COVID-19 or is otherwise sick in the past 14 days?
___	___	Have you or has anyone in your household been in close contact* with anyone who has been tested for COVID-19 and is waiting for results?
___	___	Have you or has anyone in your household been sick in the past 14 days, or have you or they been tested for any illness and are waiting for results?
___	___	Has anyone in your household been exposed to an individual known or suspected to have COVID-19 in the past 14 days?
___	___	Have you or has anyone you have been in close contact* with traveled on a cruise ship or internationally or to an area with a known communicable disease outbreak in the last 14 days?

If the answer is yes to either of these questions, the entire household must stay home.

*According to the Centers for Disease Control and Prevention (CDC), "close contact" means:

- You were within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period
- You had direct physical contact (hugged or kissed)
- You shared eating or drinking utensils
- An infected person sneezed, coughed, or otherwise got respiratory droplets on you.

Section 2

Do you or any of your immediate family had any of the following new or worsening signs or symptoms?

Yes	No	
___	___	Shortness of breath
___	___	Cough
___	___	Fever of 100.0 F or greater
___	___	Flu-like symptoms
___	___	Repeated shaking with chills
___	___	Fatigue
___	___	Muscle or body aches
___	___	Headache
___	___	Sore throat
___	___	Loss of taste or smell
___	___	Vomiting or nausea
___	___	Diarrhea

If the answer is yes to any of the symptoms above, the entire household must stay home.

Parent Signature: _____ Date: _____