



# Connecticut Yankee Council, BSA

## COVID-19 Pre-Event Medical Screening Checklist

Name: \_\_\_\_\_ Unit/Campsite: \_\_\_\_\_ Date: \_\_\_\_\_

Review with each youth and adult participant their current health status, both before departure and upon arrival at the event. Everyone entering a camp or event must be screened.

- Yes    No   Are you currently in quarantine for COVID-19 exposure or due to contact tracing?
- Yes    No   Are you currently waiting for the results of a COVID-19 test?

**In the past 14 days, have you or has anyone in your household...**

- Yes    No   - been in close contact with anyone known or suspected to have COVID-19?
- Yes    No   - been in close contact with anyone who is waiting for results of a COVID-19 test?
- Yes    No   - been sick?
- Yes    No   - travelled outside of the United States?

\* CDC definition of "Close Contact": Within 6 feet of someone who has COVID-19 for a cumulative total of 15+ minutes over a 24-hour period; direct physical contact with an infected person (hugged or kissed them); shared eating or drinking utensils; an infected person sneezed or coughed on you

**If the answer is YES to any question above, you should stay home.**  
**If the answer is NO to all questions above, proceed to the symptoms below**

**If anyone in your household has any one of the following new or worsening signs or symptoms of possible COVID-19, the entire household must stay home.**

- |   |   |                                   |
|---|---|-----------------------------------|
| <input type="checkbox"/> Shortness of breath  | <input type="checkbox"/> Fever of 100 F or more | <input type="checkbox"/> Cough    |
| <input type="checkbox"/> Muscle or body aches | <input type="checkbox"/> Loss of taste or smell | <input type="checkbox"/> Chills   |
| <input type="checkbox"/> Sore throat          | <input type="checkbox"/> Diarrhea               | <input type="checkbox"/> Fatigue  |
| <input type="checkbox"/> Flu-like symptoms    | <input type="checkbox"/> Nausea or vomiting     | <input type="checkbox"/> Headache |

**NOTE: Potential Higher-Risk Individuals**

- Yes    No   Are you in a higher-risk category as defined by the CDC, including older adults, people with medical conditions, and those with other individual circumstances?

**If the answer is YES, we recommend you stay home. If you choose to participate, you should first discuss this with your health care provider.**

- Yes    No   Have you been vaccinated for COVID-19?   Last shot: \_\_\_\_\_
- Yes    No   Do you have a recent negative COVID-19 test?   When: \_\_\_\_\_