



CCS COVID-19 Attendee Screening Form

The following form is based on CDC guidance and must be completed by all attendees (swimmers, volunteers, officials, and facility staff) in the 24 hours prior to the event and submitted prior to entering the facility.

Name <small>Printed</small>		Date	
Name <small>Signature</small>		Temperature	
In the past 48 hours, have you had any of the following NEW symptoms?			
Yes <input type="checkbox"/> No <input type="checkbox"/>	Fever of 100 F (37.8 C) or above	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cough
Yes <input type="checkbox"/> No <input type="checkbox"/>	Trouble breathing, shortness of breath, or severe wheezing	Yes <input type="checkbox"/> No <input type="checkbox"/>	Muscle aches
Yes <input type="checkbox"/> No <input type="checkbox"/>	Chills or repeated shaking with chills	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sore throat
Yes <input type="checkbox"/> No <input type="checkbox"/>	Loss of sense of smell or taste, or a change in taste	Yes <input type="checkbox"/> No <input type="checkbox"/>	Headache
Yes <input type="checkbox"/> No <input type="checkbox"/>	Nausea, vomiting, or diarrhea		
Yes <input type="checkbox"/> No <input type="checkbox"/>	To the best of your knowledge, have you been in close proximity to any individual who tested positive for COVID-19?		
Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19?		
Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you been within 6 feet of a person with a lab-confirmed case of COVID-19 for at least five (5) minutes, or had direct contact with their mucus or saliva, in the past 14 days?		
Yes <input type="checkbox"/> No <input type="checkbox"/>	Has a public health official advised you to get tested for COVID-19?		
Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you or anyone in your household been tested for COVID-19?		
Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you or anyone in your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the past 30 days?		
Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you or anyone in your household traveled on a public conveyance (airplane, bus, train, etc.) in the U.S. in the past 21 days?		
Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you or anyone in your household a health care provider or emergency responder?		
Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19?		

The event host shall keep all original CCS COVID-19 Attendee Screening Forms for no less than 90 days following the completion of the event or until directed by CCS to dispose of them.