AABR Day Services
COVID-19 Daily Health Screening Attestation Form

(Complete Prior to Entrance at AABR Day Program Locations/ Boarding Transportation Vehicle)

Date (mm/dd/yyyy): ____/____/_____ Individual: _____

Person Completing this Form:

Contact Information: Name: _____

Telephone #: _____ Home ☐ Cell ☐

Address: _____

Relationship: _____ Email: _____

1. In the past 14 days have you experienced any symptoms of COVID-19? ☐ Yes ☐ No
    a. Fever or chills
    b. Cough
    c. Shortness of breath or difficulty breathing
    d. Fatigue
    e. Muscle or body aches
    f. Headache
    g. New loss of taste or smell
    h. Sore throat
    i. Congestion or runny nose
    j. Nausea or vomiting
    k. Diarrhea
2. . Does the above-named person have a temperature greater than or equal to 100 degrees Fahrenheit? ☐ Yes ☐ No
3. In the past 14 days has this person tested positive for COVID-19? ☐ Yes ☐ No
4. In the past 14 days has there been close contact with someone known to have COVID-19 or anyone under investigation for COVID-19? ☐ Yes ☐ No
5. In the past 14 days have you traveled to or from one of CDC designated high-risk COVID-19 Hotspot countries/states/areas, on any cruise ship or to any area identified by your local government as a high-risk area? ☐ Yes ☐ No

For AABR Designee Use Only: (*Note: all the above questions must be answered)*

Location(s)/Program: _____

This form will be reviewed upon submission. If the answer to any of the above questions is "yes", the person will be denied entry to the location.

Form reviewed by (print name): _____

Title: _____ Date: _____

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For AABR Designee Use Only:

NOTES:

- **T*his form must be completed and reviewed prior to entry into AABR Day Program locations/ boarding transportation vehicle)***
- **Any concerns or questions that arise must be discussed with the Program Director/Assistant Program Director/ Director of Day Services/ Program Nurse/ Director of Nursing prior to entry**
- **The symptoms check must be completed**
- **Face mask must be worn or provided**
- **Family/Advocate/Individual identify who is completing this form**
- **All Agency COVID-19 guidelines must be implemented and completed**
- **This completed form must be immediately filed in the designated binder**

COMMENTS/CONCERNS:

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Signature: _____ Title: _____ Date: _____