Connecticut Yankee Council, BSA
COVID-19 Pre-Event Medical Screening Checklist (Rev 01/01/2022)

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?
- ❑ **Yes** ❑ **No** Are you currently ill or have you been ill at any time in the past 10 days?

For unvaccinated individuals: at any time in the past 10 days, have you…

- ❑ **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** - 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 you OR if anyone in your household has any one or more of the following new or worsening symptoms consistent with COVID-19, all people in the household, vaccinated or unvaccinated, should stay home.

❑ Shortness of breath	❑ Fever of 100 F or more	❑ Cough
❑ Muscle or body aches	❑ Loss of taste or smell	❑ Chills
❑ Sore throat	❑ Diarrhea	❑ Fatigue
❑ Flu-like symptoms	❑ Nausea or vomiting	❑ 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?
  First or only shot: _____
  Second shot: _____
  Booster shot: _____
- ❑ **Yes** ❑ **No** Do you have recent negative COVID-19 test?
  Test Date: _____