Adult Community Services COVID-19 Daily Screening Form

Please complete this form daily before your participant leaves for program and email it to ACS staff at least 15 minutes prior to the start of program. asanchez@escnj.us; sjasinski@escnj.us; sjenkins@escnj.us; rslater@escnj.us

Date: _____

Participant **Initials**: _____

SECTION 1: Has your participant experienced any of the following symptoms within the last 24 hours

☐Fever (measured or subjective)
☐Chills
☐Muscle pain
☐Headache
☐Sore Throat
☐Nausea or vomiting
☐Diarrhea
☐Fatigue
☐Congestion or runny nose
☐None of the above

SECTION 2: Have you experienced any of the following symptoms within the last 24 hours?

☐Cough
☐Difficulty breathing
☐New loss of smell
☐New loss of taste
☐Shortness of breath
☐None of the above

SECTION 3: Close Contact/Potential Exposure: Please verify if

☐ You have had close contact (within 6 feet of an infected person for a cumulative time of 15 minutes in a 24-hour period) with a person with a lab-confirmed case of COVID-19, or had direct contact with their mucus or saliva, in the last 14 days?
☐ Someone in your household is diagnosed with COVID-19
☐ You have traveled to/returned from one of the states/regions for which NJ has issued travel advisory (areas of high community transmission)?
☐ None of the above

Participants who are sick **should not** attend program in-person. If TWO OR MORE of the fields in SECTION 1 are checked off OR AT LEAST ONE field in SECTION 2 is checked off, please keep your participant home and notify the program for further instructions.

If ANY of the fields in SECTION 3 are checked off, your participant should remain home for 14 days from the last date of exposure (if participant is a close contact of a confirmed COVID-19 case) or date of return to New Jersey.

Contact your participant's health care provider or your health department for further guidance.