<u>This Form must be completed, signed, and turned in at Sunday Check-in Day.</u>
(fully vaccinated is two weeks after your final vaccination shot is administered)

Staff & Participant Questionnaire:

*Participants include athletes, coaches, and any other required support staff that are essential to the delivery of the competition, training, or camp program. (****Please complete and sign this form the morning of <u>Sunday Check-in</u>****.)*

Camper Last Name: _____ FirstName_____
MAFH Camp Session: _____

<u>Mandatory</u>: Proof (if you have it electronically, take a screen shot or print copy) of a negative Covid-19 test at Sunday check-in of a Covid 19 PCR test taken within three days of your arrival to camp or rapid antigen test taken within one day of your arrival at camp. Test must be administered/monitored from trained medical personnel (**no** at home self-administered tests accepted.) **Arriving Sunday** = <u>PCR test</u> taken no earlier than Thursday; <u>Rapid antigen</u> test taken no earlier than Saturday.

<u>Recommended</u> - Covid 19 vaccination: Yes ____ No _____Date: _____ (of last shot)
Please provide a copy of the Covid-19 Vaccination Record Card (**Upload** to your registration member dashboard)
<u>Temperature</u>: _____°F Date: _____ (<u>taken at home Sunday morning of check-in day</u>)
If any responses below are "Yes" the participant will not be allowed to enter the camp session or venue. Close contact refers to being within 6-feet for more than 15 consecutive minutes in a 24-hour period without PPE.

- I have tested positive for COVID-19 in the past 10 days: Yes ____ No ____Date: _____

- I have been in close contact with someone who has tested positive or is confirmed to have COVID-19 within the last 10 days: Yes ____ No _____
  If <u>fully vaccinated</u> and no symptoms, participant will be allowed to attend.
  (fully vaccinated is two weeks after your final vaccination shot is administered).

- Experiencing symptoms of COVID-19

Fever/Chills:	Yes ____	No _____	Headache:	Yes ____	No _____
Cough:	Yes ____	No _____	Diarrhea:	Yes ____	No _____
Sore Throat:	Yes ____	No _____	Fatigue:	Yes ____	No _____
Nausea/Vomiting:	Yes ____	No _____			
Congestion/Runny Nose:	Yes ____	No _____			
Muscle or Body aches:	Yes ____	No _____			
Shortness of Breath or difficulty breathing:		Yes ____	No _____		
New Loss of Taste/Smell:		Yes ____	No _____		

_____ Date: _____
PARTICIPANT SIGNATURE

_____ Date: _____
PARENT/GUARDIAN SIGNATURE

***Subject to changes as CDC/Local update recommended guidelines for resident camps.**