This Form must be completed, signed, and turned in at Sunday Check-in Day
***Subject to changes as CDC/Local update recommended guidelines for resident camps.**

Staff & Participant Wellness Questionnaire for Mid-Atlantic Field Hockey Camp:
*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 Sunday Check-in__.)*

Camper Last Name: ________________________ First Name____________________

MAFH Camp Session: ____________________________________

Recommended: COVID-19 vaccine series at least 14 days prior to arrival at camp? Yes __ No__
If yes, please, *attach a copy of your COVID vaccination card.* *Used for Isolation/Exposure Purpose Only.*

Recommended: Participants take a rapid Covid-19 home test within one day of checking into your camp session. (no later than the morning of your arrival). This test must be administered by a parent/guardian or trained medical personnel.

Mandatory: **Temperature**__________°F Date: _______ (taken at home Sunday morning of check-in day)

If your child was diagnosed with COVID-19 in the last 6 months, has your child visited their pediatrician for a post-illness visit prior to returning to physical activity? Yes ____ No _____

Has your child had any other medical concern / illness within the last 6 months? Yes ____ No _____

Name or type of illness: _____________________________Date Released Back to Play ______

Please attach a copy of note from your child's doctor indicating that they are cleared to participate in the physical activity of a residential sports camp.

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.
*Current CDC Isolation and Exposure Calculator will be followed.

- 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 fully vaccinated and no symptoms, participant will follow Isolation and Exposure Calculator
  (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 _____

I certify that the above information is complete and accurate
____Date: _______
*SIGNATURE OF PARENT OR GUARDIAN (*parent signature must be signed for the camper to attend camp.)