

COVID-19 Proof of Screening Form for _____

Participant's Printed Name

Witness _____ Date: _____ (initial each occurrence)

Printed Name of Fellowship Baptist Students Ministry Volunteer

Our Statement:

To do our part in preventing the spread of COVID-19 in our community and workplace, and to keep all participants and volunteers as safe as reasonably possible, we cannot permit the participation of anyone who may have been exposed to the virus, or shown any of the symptoms of the virus as described below, in our youth ministry 2021 activities. Thank you for understanding. **Please read this carefully.**

By signing this document I, _____ (the parent/guardian) give my child _____ permission to participate in the youth ministry activities of Fellowship Baptist Church. By allowing my child to participate in the youth ministry activities, I realize the inherent risks associated with COVID-19.

Each participant of our 2021 DNOW, and MFUGE Summer Camp must complete this form at the time of check in:

- Have each parent and participating student sign this *Proof of Screening Form*
- Take the temperature of each participant (normal range will be accepted)
temp taken participants temp: _____
- Ask the following questions of each participant:
 - You have not in the last 14 days had any close contact with anyone who is either confirmed or suspected of being infected with COVID-19, including anyone who was experiencing or displaying any of the known symptoms of COVID-19, AND
 - You have not in the last month traveled out of the country AND [Asked and checked:]
 - You are not currently under mandatory quarantine by your school, doctor or some other organization because of exposure to COVID-19
- You do not currently experience or display, and you have not in the last 14 days experienced or displayed, any of the following symptoms:

S M T W T F S

- Elevated temperature or fever of 100.4 F or higher
- Cough
- Shortness of breath and/or difficulty breathing
- Loss of smell and/or taste
- Fatigue, muscle aches, chills, shaking, or
- Persistent headaches

(Asked and checked off)

Thank you for your cooperation.

Signature of parent/guardian _____ Date _____ Signature of student _____ Date _____



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