

LI SPORTS DOME CHECKLIST

COVID-19 Screening Checklist for Clients

Name _____ Date _____ Time _____

Purpose: Based on the US Center for Disease Control Guidelines, service providers, daily, are encouraged to screen all clients for signs of respiratory illness accompanied by fever.

Instructions: All clients entering LI Sports Domes building must be asked the following questions below. LI Sports Dome will maintain this record for 14 days from completion of this form and have this form available upon request from the Public Health Department.

By checking this box, I pledge to provide only correct and truthful information when completing this screening.

1.) Do you have any of the following respiratory symptoms?

- New or worsening cough? ____ Yes ____ No
- New or worsening shortness of breath? ____ Yes ____ No

2. Have you had a (temperature 100.4°F or greater within the last 14 days) ____ Yes ____ No

3. Are you feeling feverish? ____ Yes ____ No

4. Are you having chills? ____ Yes ____ No

5. Have you been in a facility or home with confirmed COVID-19 by lab test within the last 14 days?
____ YES ____ NO

6. Have you been with persons with confirmed COVID-19 by lab test within the last 14 days?
____ YES ____ NO

~If YES to any, please call and cancel your appointment immediately. ~If NO to all, proceed to remaining statements. If you answered NO to all questions you will be allowed entry to building. Please be aware of the following protocols: • You will immediately sanitize your hands seconds upon entry into the building • Not to shake hands with, touch or hug others during your time in the building. I am acknowledging the potential risk to contract the COVID-19 disease during services provided today and voluntarily agreed to accept services. You further agree and hereby release LI Sports Dome and its employees from any and all liability associated with your potential risk to contract NOVEL CORONAVIRUS (COVID-19). * The person answering YES to any of the above questions is responsible for following-up with their primary care physician if needed. Client's Full

Name: (please print) _____ Client's
Signature _____ Date _____ Service
Provider's Signature _____ Date _____