

Member Health Screening

Member's Full Name (Please Print): _____

Temperature Taken by (Full Name & Please Print): _____

Members please have your mask on as you enter the building and sanitize/wash your hands before approaching screening station.

TO BE COMPLETED BY J MEMBER

Screening Questions	YES	NO
1) Are you or have you experienced any of the following symptoms of COVID-19? <ul style="list-style-type: none">• Coughing• Fever• Muscle pain• New loss of sense of taste or sense of smell• Shortness of breath/difficulty in breathing• Chills• Sore throat		
2a) Have you tested positive for COVID-19 in the past 10 days?		
2b) If you answered yes to the above questions, since then have you had 2 (two) negative tests at least 24 hours apart from one another?		
3) Have you been exposed to anyone with a confirmed or presumptive positive diagnosis for COVID 19 in the past 14 days?		
4) Have you or anyone in your household been asked to quarantine for potential COVID 19 exposure in the past 14 days?		
5) Have you traveled internationally or on a cruise ship in the past 14 days?		

If ALL the above are NO (#s 1, 2a, 3, 4, 5) and your temperature is below 100.4 degrees, you can proceed into the building. If question 2a is yes and question 2b is yes, you will be allowed entry. Please note:

- 1) You must wash or sanitize your hands before entering the Center and prior to leaving the Center.
- 2) You must wear your mask while in the J except when actively swimming or working out.

If ANY of the above answers are YES (#s 1, 3, 4, 5), you WILL NOT BE ALLOWED to enter the building and will be asked to return home. If question 2a is YES and 2b is NO, you WILL NOT BE ALLOWED entry. Please contact your health provider for further guidance.

Travel: International or cruise ship travelers will not be allowed entry unless a 14-day post return quarantine has been completed and no symptoms are present. This is subject to change based on CDC and state guidance.

The information I have provided above is accurate to the best of my knowledge.

Member Signature: _____ Date: _____

TO BE COMPLETED BY J STAFF:

Date of Screening: _____

Temperature Reading: _____ Second Temperature Reading (if taken): _____

Do you see any visual signs of illness (fatigue, flushed face)? _____ Yes _____ No