321 Village Road East
West Windsor, New Jersey 08550
Phone: (609) 716-5000
Fax: (609) 716-5022

Volunteer Health Screening Form

Name: _____ Date: _____
Reason for Visit: _____Accompanied by (staff member):_____
Phone Number:_____

Section 1: Symptoms

Any of the symptoms below could indicate a COVID-19 infection and may put you at risk for spreading illness to others. Please note that this list does not include all possible symptoms, and individuals with COVID-19 may experience any, all, or none of these symptoms. Please check yourself daily for these symptoms:

Group A

- ☐ Fever (measured or subjective)
- ☐ Chills
- ☐ Rigors
- ☐ Myalgia (muscle aches)
- ☐ Headache
- ☐ Sore Throat
- ☐ Nausea or Vomiting
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Congestion or Runny Nose

Group B

- ☐ Cough
- ☐ Shortness of Breath
- ☐ Difficulty Breathing
- ☐ New loss of taste
- ☐ New loss of smell

IF TWO OR MORE of the fields in Group A are checked off OR AT LEAST ONE field in Group B is checked off, regardless of vaccination status, please stay home and notify the school nurse/administrator for further instructions.

Section 2: Close Contact/Travel

- ☐ NONE of the below
- ☐ You have had close contact (within 6 feet of an infected person for a total of 15 minutes or more over a 24 hour period) with a person with confirmed COVID-19.
- ☐ Someone in your household is diagnosed with COVID-19 or is symptomatic for COVID-19 and has at least two symptoms from column A or one from column B per the above symptom checklist.
- ☐ You have traveled out of the country (**regardless of vaccination status, contact school nurse/administrator)**
- ☐ You have traveled to an area of high community transmission and you are not fully vaccinated (2 weeks past 2nd vaccine).
  Please visit covid19.nj.gov for the current list

If ANY fields in Section 2 are checked, you should remain home for 10 days from the last date of exposure or date of return to New Jersey. If someone in your household is ill with COVID-19 or COVID-19 symptoms, please stay home and notify the school nurse/administrator for further instructions.

Section 3: Vaccination Status

- ☐ I have been fully vaccinated for COVID-19 (2 weeks have passed since my final dose of the complete series). I agree to provide proof of vaccination to a WW-P administrator or designee.

I attest that this form is filled out accurately and to the best of my knowledge.

Signature: _____

FOR OFFICE USE ONLY: ___ Proof of Vaccination reviewed on _____ by _____