CITY OF MALIBU COMMUNITY SERVICES DEPARTMENT

COVID-19 PARTICIPANT HEALTH CERTIFICATION FORM

Prior to the start of a City of Malibu Community Services Department program, all participants will complete a COVID-19 Participant Health Certification Form. Upon completion, please submit the completed questionnaire to City staff. The City will maintain all health information as a confidential medical record in compliance with state and federal law, including but not limited to, the Americans with Disabilities Act and the Confidentiality of Medical Information Act.

1. Does the participant have any of the following symptoms? (Check if YES)

☐ Cough ☐ Muscle pain ☐ Shortness of breath

☐ Sore throat ☐ Fever ☐ New loss of taste or smell

☐ Chills ☐ ***NO symptoms***

If YES, return home and contact your healthcare provider.

If NO to all, proceed to remaining questions.

2. Temperature check: ☐ **Fever below 100.4** ☐ **Fever above 100.4**

****Any temperature 100.4 F or greater is considered a fever.**

If temperature is above 100.4 F, return home and contact your healthcare provider.

If NO, proceed to remaining questions.

3. Has the participant had close contact with an individual diagnosed with COVID-19? *Close contact means within 6-feet or coming in direct contact with secretions (e.g., sharing utensils, being coughed or sneezed on, etc.). The timeframe for having contact with an individual includes the period of 48 hours before the individual became symptomatic.*

☐ YES ☐ NO **If YES, return home and contact your healthcare provider.**

If NO, proceed to remaining question.

4. Has the participant been asked to self-isolate or quarantine by your doctor or local public health official?

☐ YES ☐ NO **If YES, return home and contact your healthcare provider.**

If NO, to this question and all others, sign below and enter the workplace.

I certify that my responses are truthful and accurate to the best of my knowledge. I further understand that if the participant develops any of the above symptoms, they will be separated from other participants and the Emergency Contact will be notified for immediate pick-up.

_____ _____ _____

Participant Name Adult/Parent/Guardian Signature Date

City Use Only

Name of Program: _____ Dates of Program: _____

Temperature Checks: _____ Monday _____ Tuesday _____ Wednesday _____ Thursday

Staff Initials Temp. Checks: _____ Monday _____ Tuesday _____ Wednesday _____ Thursday