



Program Participant - COVID Screening Questions and Health-Certification

By signing below, you are verifying that the program participant(s) do(es) not have any of the following COVID-19 symptoms (listed below), that they have not been in close contact with any persons with these symptoms, and that they feel well today. Symptoms include:

- Cough
- Shortness of breath

Or at least two of these symptoms:

- Fever
- Chills
- Repeated shaking with chills
- Muscle pain
- Headache
- Sore throat
- New loss of taste or smell

Less common symptoms also include fatigue, vomiting and diarrhea

I certify that _____ does not have any of the COVID-19 symptoms specified above nor have they been in close contact with anyone experiencing the symptoms or being tested/tested positive for COVID-19. I also certify that by participating in a registered program, participants will follow the Garden's recommended guidelines for physical distancing, will wear a mask when within 6 feet of others and will follow all of the other general guidelines provided by program instructors.

Date	Name (printed)	Signature

Note: Participant should retain one copy for continual reference in regards to symptoms; the Garden will retain the signed copy in the program file.