

Covid-19 Safety Review Waiver

Please review the following list. Please mark "yes" if your child or anyone in your household has experienced any of these symptoms in the past 24 hours. If no one in your household has experienced the symptoms, please indicate with "no."

_____ Fever (Temperature of 100.0°F or above)

_____ Felt Feverish or had chills

_____ Cough

_____ Sore Throat

_____ Difficulty Breathing

_____ Gastrointestinal symptoms (diarrhea, nausea, vomiting)?

_____ Fatigue (Fatigue alone does not exclude a child from participation)

_____ Headache

_____ New loss of smell/taste

_____ New muscle aches

_____ Any other signs of illness(Please describe_____)

In the past 14 days, have you or any one in your household had close contact with a person known to be infected with the novel coronavirus (COVID-19)? _____

By signing this Waiver, I confirm that the above is true and that should any of these symptoms appear or any of these circumstances change over the duration of this program, I am obligated to inform The Hingham Recreation Department of this change

(Signature)

(Name Printed)

Date