Ms. J's Gymnastics COVID-19 Policy & Procedures 2020-2021

Welcome Back!

We are excited to be able to open our doors, turn the lights on, and have the energy of children and coaches back in our gym! We have missed all of you and thank you for your support during this trying time.

We ask you to read through our new policy and procedures, sign and date the last page and hand into your child's coach upon the first day of class. We thank you for your respect and compliance during this time. We have put time and careful thought into making the most of your experience here at Ms. J's gymnastics.

Firstly, we want you to know that we will be taking every precaution in following the CDC protocol, NY Guidelines, OSHA, as well as the recommendations from USA Gymnastics and the American Red Cross. Your safety has always been our number one priority and we will continue making this our number one goal!

You will notice that we have and will continue to make adjustments to our classes as needed. We will be spacing out class times to allow for extra cleaning and social distancing. As always, hand sanitizer will be readily available around the gym.

We have taken great pride in keeping our student to coach ratios low and to help keep students and staff safe, we will be lowering some of our class ratios even more. This will help allow time for staff to sanitize equipment in between classes. We assure you that your class will still be full of gymnastics!

Just as before we closed, classes will run with excitement and fun. Students will continue to work towards their goals while practicing social distancing and through the use of more stations spread out on each event!

Staff Responsibilities:

- Will wear a mask while coaching at all times.
- Will sanitize hands prior, throughout and after classes.
- Will sanitize equipment right after class & during when it is necessary.
- Will wear non-latex gloves when spotting.
- Will have their temperature checked by management upon arrival.
- If Staff has been sick or around anyone with symptoms in the last 14 days, a Sub will be called in.

Upon Arrival: Parent/ Athlete Responsibilities:

- ALL must go to the main gym for a temperature check at their arrival.
- Families may not arrive earlier than the designated time of their program to alleviate congestion.
- Anyone over the age of 2 years is required to wear a mask at all times with the exception of when a coach permits a socially distant athlete to unmask for a high level skill.
- Hands must be washed or sanitized as soon as entering the gym and immediately after class: Parent and Athlete.
- Please do not linger after your program to help decrease congestion.

Questions to Ask yourself:

-Have you had a cough?
-Have you had a fever?
-Have you been around anyone exhibiting these symptoms within the
-past 14 days?
-Are you living with anyone who is sick or quarantined?

* If you answer yes to any of these questions, you will be asked to reschedule your enrollment.

Please do not schedule makeups with your instructor. Contact the office by email at msjsgym@gmail.com

Try to refrain from bringing excess belongings into the gym that are not needed.

There is no Lost & Found during these times.

Gym Area:

- Gymnasts over the age of 2yrs must wear masks at all times with the exception of socially distant gymnasts performing a high level skill.
- Stations for events will be spread out. There will be no in-line waiting for turns.
- Students will get a drink or use the restroom one at a time when needed.
- Equipment/mats will be cleaned after each class, and as much possible in between rotations.
- Chalk will not be available in our chalk bin (Students must bring their own).

Advanced/ Team athletes must have their own chalk. A limited quantity is available for sale (cash only) Think about purchasing your own scrapper.

- Please be sure to bring a water bottle with your child's name written on the bottle. (We end up recycling many!)

Spotting/ Hands On: In the sport of gymnastics, it is extremely important for coaches to spot students during skills to ensure safety. Spotting and hands on coaching is also crucial when learning and progressing to new skills. Alternate methods, such as extra drill stations for progressions, will help eliminate some hands on; however, coaches will continue to spot gymnasts when it is necessary.

Lobby: Ms. J's Gymnastics has always been an open facility for the pleasure of viewing your child's class. To be able to accommodate safety, if possible, we ask you to drop students off and return 15 minutes before the class ends. This is recommended but not required (as we might not be able to accommodate you due to lowered lobby and viewing area capacities or based on a program's policies).

***No eating permitted within the gym, lobby, or viewing areas**

(Vending machine will be open for drinks, takeaway use, or for gymnasts in drop-off programs \\ EXACT CHANGE ONLY- no credit cards)

***Masks must be worn if staying to watch a class.**

***One adult/guardian per student allowed to stay in the lobby. *Absolutely no "extra" siblings, friends allowed.**

***Our chairs will be placed 6 feet apart, please keep them in their place.**

***Please stay seated or near your chair and do your best to refrain from leaning against cubbies.**

- We will clean chairs as much as possible in between classes and will have wipes available for your use if you would like to clean a chair before taking a seat.

Pro-Shop and Leotard Sales: Our Pro-Shop will still be open. We have always recommended trying on a leotard before purchasing but we do not foresee this being done safely. Ms. J's gymnastics wear: such as T-shirts and sweatpants, will be available for purchase. There will be no returns allowed.

Restrooms: We will do our best to keep our restrooms extra clean during this time. We ask that you to take note of if someone is in the restroom prior to entering. We ask no more than two at a time. If you see that soap or any other disinfecting products is getting low, please let the front desk know to refill it.

Ms. J's Gymnastics and Dance Primary Health Screening Questionnaire

Please complete the following to the best of your knowledge before your child enters Ms. J's Gymnastics. If the individual answers YES to any of the questions they will not be allowed into the facility/office unless determined otherwise by a designated medical professional.

1. Within the last 14-days, have you experienced a new cough that you cannot attribute to another health condition? ☐ YES ☐ NO

2. Within the last 14-days, have you experienced new shortness of breath that you cannot attribute to another health condition? ☐ YES ☐ NO

3. Within the last 14-days, have you experienced a new sore throat that you cannot attribute to another health condition? ☐ YES ☐ NO

4. Within the last 14-days, have you experienced new muscle aches that you cannot attribute to another health condition or a specific activity such as physical exercise? ☐ YES ☐ NO

5. Within the last 14-days, have you had a temperature at or above 100° or the sense of having a fever? ☐ YES ☐ NO

6. Within the last 14 days, have you had close contact, without the use of appropriate personal protective equipment, with someone who is currently sick with suspected or confirmed COVID-19?* (Note: Close contact is defined as within 6 feet for more than 10 consecutive minutes) ☐ YES ☐ NO

7. Within the last 14 days, have you traveled anywhere with a high number of cases? ☐ YES ☐ NO If YES, where?:_____

I certify all these answers have been answered to my full knowledge and are truthful.

Childs name: _____ Guardian's name: _____

Guardian's Signature: _____ Date: _____

Ms. J's 2020 Risk & Waiver for COVID-19 Virus

Please read and sign the Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19 below. This must be signed before your child enters the gym. If you have any questions, contact msjsgym@gmail.com

Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

We are currently in a stage of reopening that allows our Summer program to reopen under certain guidelines. The guidelines include but is not limited to, checking health status and temperature upon arrival, limiting group sizes to 10, keeping groups together all day without contact from other students, maintaining the same teacher throughout the day, requiring staff to wear masks, enforcing social distancing, mandatory intervals of handwashing, and immediate isolation is symptoms appear.

Ms. J's Gymnastics and Dance has put in place preventative measures to reduce the spread of COVID-19; however, Ms. J's Gymnastics and Dance cannot guarantee that you or your child(ren) will not become infected with COVID-19. Further, attending Ms. J's Gymnastics and Dance could increase your risk and your child(ren)'s risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my child(ren) and I may be exposed to or infected by COVID-19 by attending Ms. J's Gymnastics and Dance and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at Ms. J's Gymnastics and Dance may result from the actions, omissions, or negligence of

myself and others, including, but not limited to, Ms. J's Gymnastics and Dance employees, and program participants and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to my child(ren) or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my child(ren)'s attendance at Ms. J's Gymnastics and Dance or participation in Ms. J's Gymnastics and Dance programming. On my behalf, and on behalf of my children, I hereby release, covenant not to sue, discharge, and hold harmless Ms. J's Gymnastics and Dance, its employees, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of Ms. J's Gymnastics and Dance, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any Ms. J's Gymnastics and Dance program.

I understand that any payments or fees will not be refunded should a class or program be closed temporarily or for the remainder of the session due to safety concerns, the decision of local, county, state or federal health authorities, camp / program director, or management. Any tuition not used due to COVID-19 related reasons will be applied as a Ms. J's credit for future use. Please review individual program policies that specifically apply to each program.

Child's Name: (please print) Guardian's Name: (please print)

_____ _____

Guardian's Signature:_____Date:_____

Ms. J's Gymnastics & Dance Secondary Health Screening Questionnaire

Please sign at the bottom of these statements if ALL statements apply and are true.
If any statement does not apply, please complete a Primary Health Screening Questionnaire.

-I have taken my child's temperature upon arrival at Ms. J's and it is under 100 degrees.
-I have previously completed my Primary Health Screening Questionnaire.
-I have no health updates since my last day attending the gym.
-I have no health updates since last completing my Primary Health Screening Form.
-If I have a health update within 14 days of attending Ms. J's Gymnastics and Dance, I will contact Ms. J's Gymnastics and Dance.
-I certify all these answers have been answered to my full knowledge and are truthful.
-I agree to any safety updates put in place by the gym.

Childs name:(please print) _____

Guardian's name: (please print) _____

Guardian's Signature:_____ Date: _____

Date	Fever above 100F (Y/N)	Temperature check by (staff initials)	Your Initials

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | Sex ☐ Female ☐ Male | Date of Birth (Month/Day/Year) ___/___/___

Child's Address | Hispanic/Latino? ☐ Yes ☐ No | Race (Check ALL that apply) ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other

City/Borough | State | Zip Code | School/Center/Camp Name | District ___ Number ___ | Phone Numbers: Home / Cell / Work

Health Insurance (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian ☐ Foster Parent | Last Name | First Name | Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history (age 0-6 yrs)

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs (list) _____

☐ Foods (list) _____

☐ Other (list) _____

Attach MAF in in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF)* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____

Explain all checked items above. ☐ *Addendum attached.*

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

_____

_____

_____

_____

PHYSICAL EXAM Date of Exam: ___/___/___

Height _____ cm (___ ___ %ile)

Weight _____ kg (___ ___ %ile)

BMI _____ kg/m² (___ ___ %ile)

Head Circumference (age ≤2 yrs) _____ cm (___ ___ %ile)

Blood Pressure (age ≥3 yrs) _____ / _____

General Appearance:

☐ Physical Exam WNL

N	Abn		N	Abn		N	Abn		N	Abn
☐	☐	Psychosocial Development	☐	☐	HEENT	☐	☐	Lymph nodes	☐	☐ Abdomen
☐	☐	Language	☐	☐	Dental	☐	☐	Lungs	☐	☐ Genitourinary
☐	☐	Behavioral	☐	☐	Neck	☐	☐	Cardiovascular	☐	☐ Extremities

N	Abn	
☐	☐	Skin
☐	☐	Neurological
☐	☐	Back/spine

Describe abnormalities:

DEVELOPMENTAL (age 0-6 yrs)

Validated Screening Tool Used? ☐ Yes ☐ No | Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: _____

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	___/___/___	_____ µg/dL
	___/___/___	_____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	___/___/___	☐ At risk *(do BLL)* ☐ Not at risk

— Child Care Only —

Hemoglobin or Hematocrit	___/___/___	_____ g/dL _____ %

Hearing	Date Done	Results
< 4 years: gross hearing	___/___/___	☐ N ☐ Abn ☐ Referred
OAE	___/___/___	☐ N ☐ Abn ☐ Referred
≥ 4 yrs: pure tone audiometry	___/___/___	☐ N ☐ Abn ☐ Referred

Vision	Date Done	Results
<3 years: Vision appears:	___/___/___	☐ N ☐ Abn
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ___/___ Left ___/___ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental

Visible Tooth Decay ☐ Yes ☐ No

Urgent need for dental referral *(pain, swelling, infection)* ☐ Yes ☐ No

Dental Visit within the past 12 months ☐ Yes ☐ No

CIR Number

Physician Confirmed History of Varicella Infection ☐

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___

Tdap	___/___/___	___/___/___		
MMR	___/___/___	___/___/___		
Varicella	___/___/___	___/___/___		
Mening ACWY	___/___/___	___/___/___		
Hep A	___/___/___	___/___/___		
Rotavirus	___/___/___	___/___/___		
Mening B	___/___/___	___/___/___		
Other _____	___/___/___	___/___/___		

Report only positive immunity:

IgG Titers	Date
Hepatitis B	___/___/___
Measles	___/___/___
Mumps	___/___/___
Rubella	___/___/___
Varicella	___/___/___
Polio 1	___/___/___
Polio 2	___/___/___
Polio 3	___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* | **ICD-10 Code**

_____ _____

_____ _____

_____ _____

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions (specify) _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: ___/___/___

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other _____

Health Care Practitioner Signature | Date Form Completed ___/___/___

Health Care Practitioner Name and Degree *(print)* | Practitioner License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone | Fax | Email

DOHMH ONLY PRACTITIONER I.D.

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Date Reviewed: ___/___/___ **I.D. NUMBER**

REVIEWER:

FORM ID#