

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:

- Athletes are encouraged but not required to wear a mask through the duration of class
- Hands must be washed or sanitized as soon as entering the gym and immediately after class: Parent and Athlete

Questions to Ask yourself:

1. Have you had a cough?
2. Have you had a fever?
3. Have you been around anyone exhibiting these symptoms within the past 14 days?
4. 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 at 718-218-7065 or email at msjsgym@gmail.com

**** Family Fun & Open Workouts will be canceled until further notice. ****

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 must wear masks when social distancing cannot be maintained.
- 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 outside of the tri-state area?
☐ YES ☐ NO If YES, where? _____

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

Child's 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 if 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: _____

[illegible]

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 <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year) ____/____/____	
Child's Address					Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No		Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____				
City/Borough		State	Zip Code		School/Center/Camp Name			District Number ____		Phone Numbers Home _____ Cell _____ Work _____	
Health insurance <input type="checkbox"/> Yes (including Medicaid)? <input type="checkbox"/> No		<input type="checkbox"/> Parent/Guardian Last Name <input type="checkbox"/> Foster Parent			First Name			Email			
TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER											
Birth history (age 0-6 yrs) <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____ Allergies <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____ Attach MAF if in-school medications needed				Does the child/adolescent have a past or present medical history of the following? <input type="checkbox"/> Asthma (check severity and attach MAF): If persistent, check all current medication(s): Asthma Control Status <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Behavioral/mental health disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Orthopedic injury/disability Explain all checked items above. <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <input type="checkbox"/> Quick Relief Medication <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None <input type="checkbox"/> Well-controlled <input type="checkbox"/> Poorly Controlled or Not Controlled <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Hospitalization <input type="checkbox"/> Surgery <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Addendum attached.							
PHYSICAL EXAM Date of Exam: ____/____/____ Height _____ cm (____ %ile) Weight _____ kg (____ %ile) BMI _____ kg/m² (____ %ile) Head Circumference (age ≤3 yrs) _____ cm (____ %ile) Blood Pressure (age ≥3 yrs) _____ / _____				General Appearance: <input type="checkbox"/> Physical Exam WNL NI Abnl <input type="checkbox"/> HEENT <input type="checkbox"/> Lymph nodes <input type="checkbox"/> Abdomen <input type="checkbox"/> Skin <input type="checkbox"/> Psychosocial Development <input type="checkbox"/> Dental <input type="checkbox"/> Lungs <input type="checkbox"/> Genitourinary <input type="checkbox"/> Neurological <input type="checkbox"/> Language <input type="checkbox"/> Neck <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Extremities <input type="checkbox"/> Back/spine <input type="checkbox"/> Behavioral Describe abnormalities:							
DEVELOPMENTAL (age 0-6 yrs) Validated Screening Tool Used? _____ Date Screened ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No Screening Results: <input type="checkbox"/> WNL <input type="checkbox"/> Delay or Concern Suspected/Confirmed (specify area(s) below): <input type="checkbox"/> Cognitive/Problem Solving <input type="checkbox"/> Adaptive/Self-Help <input type="checkbox"/> Communication/Language <input type="checkbox"/> Gross Motor/Fine Motor <input type="checkbox"/> Social-Emotional or Personal-Social <input type="checkbox"/> Other Area of Concern: _____ Describe Suspected Delay or Concern:				Nutrition < 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both ≥ 1 year <input type="checkbox"/> Well-balanced <input type="checkbox"/> Needs guidance <input type="checkbox"/> Counseled <input type="checkbox"/> Referred Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> 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 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 ____/____/____ NI Abnl Referred OAE ____/____/____ NI Abnl Referred ≥ 4 yrs: pure tone audiometry ____/____/____ NI Abnl Referred Vision Date Done Results <3 years: Vision appears: ____/____/____ NI Abnl Acuity (required for new entrants and children age 3-7 years) Right ____/____/____ Left ____/____/____ Unable to test <input type="checkbox"/> Screened with Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Strabismus? <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Visible Tooth Decay <input type="checkbox"/> Yes <input type="checkbox"/> No Urgent need for dental referral (pain, swelling, infection) <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Visit within the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No			
Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No CIR Number [][][][][][][][][][] Physician Confirmed History of Varicella Infection <input type="checkbox"/>				Report only positive immunity: IgG Titers Date Hepatitis B ____/____/____ Measles ____/____/____ Mumps ____/____/____ Rubella ____/____/____ Varicella ____/____/____ Polio 1 ____/____/____ Polio 2 ____/____/____ Polio 3 ____/____/____							
IMMUNIZATIONS – DATES DTP/DTaP/DT ____/____/____ Tdap ____/____/____ Td ____/____/____ MMR ____/____/____ Polio ____/____/____ Varicella ____/____/____ Hep B ____/____/____ Mening ACWY ____/____/____ Hib ____/____/____ Hep A ____/____/____ PCV ____/____/____ Rotavirus ____/____/____ Influenza ____/____/____ Mening B ____/____/____ HPV ____/____/____ Other ____/____/____											
ASSESSMENT <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) ICD-10 Code				RECOMMENDATIONS <input type="checkbox"/> Full physical activity <input type="checkbox"/> Restrictions (specify) _____ Follow-up Needed <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ Referral(s): <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> IEP <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____							
Health Care Practitioner Signature					Date Form Completed ____/____/____			DOHMH ONLY		PRACTITIONER I.D. [][][][][][]	
Health Care Practitioner Name and Degree (print)					Practitioner License No. and State			TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s)			
Facility Name					National Provider Identifier (NPI)			Comments:			
Address City State Zip								Date Reviewed: ____/____/____ I.D. NUMBER [][][][][][]			
Telephone Fax Email								REVIEWER:			
								FORM ID# [][][][][][][][][][]			