Name: _____ Date: _____ Temperature: _____

1. Have you been in contact with someone you know, or that resides I your home that has COVID-19, or is presumed to have COVID-19 and are still under quarantine at the time of camp? Yes No
2. Have you experienced a fever of 100.4 degrees, or higher, anytime in the past 72 hours (3 days)? Yes No
3. Do you currently have a dry cough? Yes No
4. Are you experiencing shortness of breath? Yes No
5. Do you have a runny nose? Yes No
6. Do you have head or body aches? Yes No
7. Do you have a sore throat? Yes No
8. Do you have nausea, vomiting, or diarrhea? Yes No
9. Do you have a current loss of taste or smell? Yes No
10. If you answered YES to any screening question, please explain below. If your yes is due to anything UNUSUAL or OUT OF THE NORM for you, it may be best to stay home just to be safe.
11. Please describe other unusual health/wellness symptoms you may currently be experiencing.

I acknowledge and affirm that I am answering these questions to the best of my knowledge and that I have fully read and understood each of these questions in filling out this form.

Parent Signature: _____ Date: _____