

Name: _____ Date: _____ Temperature: _____

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| 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.

Signature: _____

Date: _____