



Event Self-Screening

Please record this information before your arrival to camp. Be sure to hand this form in to you leader or unit coordinator.

First Name

Last Name

Are you having any of the following symptoms?

Yes No

Cough

Shortness of breath or difficulty breathing

Sore throat

Fever

New loss of taste or smell

Was your temperature less than 100.4 degrees?

Yes

No

Have you come in contact with or cared for someone with confirmed COVID-19 in the past 14 days?

Yes

No

Statement of Understanding

I attest that the above information is accurate.