COVID-19 Self-Screening

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

_____
Date

_____ _____
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 over 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

Are you or anyone in your household awaiting the results of a COVID-19 test?

☐ Yes ☐ No

Are you or anyone in your household currently in quarantine for possible COVID-19 exposure?

☐ Yes ☐ No

Statement of Understanding

☐ I attest that the above information is accurate

Last updated 10/1/21