Basic Covid 19 Screening Questions

Are you currently feeling sick or not well?	**Yes**	**No**

Do you currently have any of the following symptoms?

***Fever specify 100.4 or higher or chills**	**Yes**	**No**
***Difficulty breathing**	**Yes**	**No**
***New or worsening cough**	**Yes**	**No**
***Loss of taste, smell or appetite**	**Yes**	**No**
***Sore Throat**	**Yes**	**No**
***Vomiting or diarrhea**	**Yes**	**No**
***Stomach pain**	**Yes**	**No**
***Body aches**	**Yes**	**No**
***Pain, rash or swelling of fingers or toes**	**Yes**	**No**
***New rash or other skin symptoms**	**Yes**	**No**
***Have you been in close contact with anyone that has tested positive for COVID-19?**	**Yes**	**No**

Signature_____

To be completed on site at camp:

Temperature Check: _____ Person Administering_____

Signature