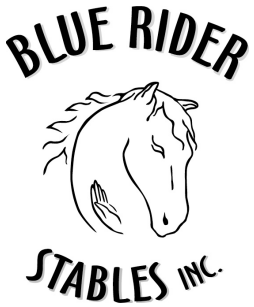

COVID-19 Temperature Questionnaire

Name _____ Date _____ Time_____

Camper ____ Student_____ Therapy____ Staff____ Other_____

Wearing Protective Face Covering_____

Temperature_____ **(If above 100 - must return home.)**

Name: _____ Temp._____

Name: _____ Temp _____

Name: _____ Temp _____

Questions:

Have you or anyone in your household traveled out of the area or to COVID-19 hotspots in the past 14 days? _____

Have you been tested for COVID 19 in the past 14 days? Results_____

Have you been exposed to COVID 19 in the past 14 days? If so, date_____.

Explain how_____

Has anyone you reside with or have close contact with been exposed or tested positive for COVID 19 in the past 14 days?

If yes explain: _____

Have you or anyone you reside with or have close contact with had a fever in the past 72 hours? _____

Do you have any of these symptoms that are abnormal for you?

- Cough
- Shortness of breath or difficulty breathing
- Fever or chills
- Fatigue
- Muscle or body aches
- Sore throat
- New loss of taste or smell
- Headache
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea