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 _____

Name: _____Temp _____

❒ **Today or in the past 24 hours, have you <u>or any member of your household</u> had any of the following:**

Fever over 100.0 F, felt feverish, had chills or taking medications to reduce fever	Y __ N __
New cough, sore throat or difficulty breathing	Y __ N __
Sudden/new or severe fatigue	Y __ N __
Sudden/new loss of smell/taste	Y __ N __
Sudden/new muscle aches	Y __ N __
Sudden or unexplained diarrhea	Y __ N __
Unexplained headache or any other signs of illness?	Y __ N __

❒ **Today or in the last 14 days, have you had close contact with any person suspected of having COVID-19?** Close contact is defined as within 6 feet for more than 15 minutes over 24 hours. Y__ N__

❒ **Today or in the last 14 days, is anyone in your household quarantining or isolating for COVID-19?** Y__ N__

❒ **In the last 14 days, have you or anyone in your household returned from a trip to another state or country?** Y__ N__

If any of these answers are yes, you will be asked to leave and not join our program. Please call or email our office to discuss how to proceed.

❒ **Visual Screening: Staff to complete**

- ❒ Does the person look and sound healthy? Y__ N __
- ❒ Are they flushed, breathing rapidly, coughing, confused or short tempered? Y__ N __