



COVID-19 QUESTIONNAIRE

PLEASE READ EACH QUESTION CAREFULLY	PLEASE CIRCLE THE ANSWER THAT APLIES TO YOU
Have you experienced any of the following symptoms in the past 48 hours: <ul style="list-style-type: none"> * fever or chills * cough * shortness of breath or difficulty breathing * fatigue * muscle or body aches * headache * new loss of taste or smell * sore throat * congestion or runny nose * nausea or vomiting * diarrhea 	YES NO
Within the past 14 days, have you been in close physical contact (Six feet or closer for a cumulative total of 15 minutes) with: <ul style="list-style-type: none"> * Anyone who is known to have a laboratory-confirmed COVID 19? <p style="text-align: center; margin: 10px 0;">OR</p> <ul style="list-style-type: none"> * Anyone who has any symptoms consistent with COVID 19? 	YES NO
Are you isolating or quarantining because you may have been exposed to a person with COVID 19 or are worried that you may be sick with COVID 19?	YES NO
Are you currently waiting on the results of a COVID 19 test?	YES NO
Did you answer NO to ALL QUESTIONS ?	We look forward to seeing you at Winter Camp!
Did you answer YES to ANY QUESTION ?	Unfortunately, you should probably not attend Winter Camp. We look forward to seeing you in the summer!
Camper Name _____ Date _____ Parent Signature _____	