Daily Health Screening Log for **Camp** _____

Date _____ **Group** Number or Name _____ **Staff** Name _____

Camper Name (print)	**Time**	**Temperature** (parent or camp optional) may not exeed **100.4^{0}F** (38.0^{0}C)	**Question1.** Have you developed ANY of the following **symptoms** of COVID-19 infection in the last ten (10) days? Y/N Fever or chills Shortness of breath? Muscle or body aches? Unusual headache? New loss of taste or smell? Nausea or vomiting? Congestion or runny nose? Difficulty breathing? Fatigue? Cough? Sore throat? Diarrhea?	**Question2:.**Have you had a **positive test** for COVID-19 infection within the past ten (10) days? Y/N	**Question3:** Within the last ten (10) days, have you been within six (6) feet for longer than 15 minutes with someone who has a suspected or confirmed COVID-19 infection, *WITHOUT taking proper precautions* like wearing a mask and frequently washing your hands during this contact period? Y/N
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9.					

Staff Name (print)	**Time**	**Temperature** (parent or camp optional) may not exeed **100.4^{0}F** (38.0^{0}C)	**Question1.** Have you developed ANY of the following symptoms of COVID-19 infection in the last ten (10) days? Y/N Fever or chills Shortness of breath? Muscle or body aches? Unusual headache? New loss of taste or smell? Nausea or vomiting? Congestion or runny nose? Difficulty breathing? Fatigue? Cough? Sore throat? Diarrhea?	**Question2:.**Have you had a positive test for COVID-19 infection within the past ten (10) days? Y/N	**Question3:** Within the last ten (10) days, have you been within six (6) feet for longer than 15 minutes with someone who has a suspected or confirmed COVID-19 infection, *WITHOUT taking proper precautions* like wearing a mask and frequently washing your hands during this contact period? Y/N
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