COVID Screening Questionnaire

Future Stars Summer Camp 2020

Name of Camper: ____

Temperature on morning of camp: ______ °F

Please mark Yes/No for each symptom listed in the table below.

In the past 14 days, has the camper experienced:	Yes	No
Fever/Chills (100.4 °F or greater)		
Cough		
Difficulty Breathing (separate from usual difficulty if the camper has a history of asthma or other respiratory conditions)		
Fatigue		
Muscle/Body Aches		
Headache		
Sore Throat		
Congestion/Runny Nose		
Nausea/Vomiting		
Diarrhea		
New loss of Taste/Smell		

In the last 14 days, has the camper had household contact or other close contact with someone with the above symptoms or travel history?

In the last 14 days, has the camper had household contact or other close contact with someone with a confirmed diagnosis of COVID-19?

Please be mindful that you should be aware of state and local guidelines regarding mandates, self-quarantines for inter-state travelers, and precautions to help stop the spread of COVID-19.