COVID-19 Health Assessment (Summer 2021)

Child's Name: _____ Camp Date: _____

Please Read Each Question Carefully	Please Circle the Answer that Applies to the Camper
Has your child experienced any COVID-19 related symptoms in the last 48 hours? ● Fever ● Cough/Sore Throat ● Shortness of Breath ● Headaches ● Loss of taste or smell	YES NO
Has your child been in close contact with anyone who has been exposed, or is showing symptoms of COVID-19?	YES NO
Is your child currently waiting on the results of a COVID-19 test?	YES NO
Have you traveled outside of the state in the last 10 days?	YES NO

If you responded yes to any of the above questions, your child will not be able to attend camp that day. If you have any questions or concerns, please speak to the camp director.

Parent Signature: _____ Date: _____