Township of Washington Summer Camp Daily Pre-Screening Questionnaire

Name of Camper/Counselor: _____

Parent/Guardian Cell: _____

Signature acknowledging review of this form (If under 18):_____

Are you experiencing any of the following symptoms?	**Please Circle One**	
1. Fever	**YES**	**NO**
2. Cough or shortness of breath	**YES**	**NO**
3. Sore Throat	**YES**	**NO**
4. Chills	**YES**	**NO**
5. Muscle aches or rigors	**YES**	**NO**
6. Headache	**YES**	**NO**
7. New loss of taste or smell	**YES**	**NO**
8. Abdominal pain, nausea, vomiting, or diarrhea	**YES**	**NO**
9. Have you had close contact with someone who is currently sick?	**YES**	**NO**
10. Have you been diagnosed with COVID - 19 in the past three weeks or have reason to believe you have COVID - 19?	**YES**	**NO**
11. Have you traveled or had close contact with anyone who has traveled internationally in the last 14 days?	**YES**	**NO**
12. If you took your temperature this morning, what was the reading?		

- **To participate in camp, each camper/counselor (Or guardian if under 18) must complete this form daily before entering camp.**