Daily Check-In Screening Form

Please Circle an Answer for each one and sign off at the bottom. If yes is answered to any of these questions your child may not attend.

CHILDS NAME:_________________________________  DAY/DATE:________________

1) Today or in the past 24 hours, have you or any household members had any of the following symptoms?

• Fever (temperature of 100.0°F or above), felt feverish, or had chills?
• Cough?
• Sore throat?
• Difficulty breathing?
• Gastrointestinal symptoms (diarrhea, nausea, vomiting)?
• Abdominal pain?
• Unexplained Rash?
• Fatigue?
• Headache?
• New loss of smell/taste?
• New muscle aches?
• Any other signs of illness?

Yes or No

2) In the past 14 days, have you had close contact with a person known to be infected with the novel coronavirus (COVID-19)?

• Unexplained Rash?
• Fatigue?
• Headache?
• New loss of smell/taste?
• New muscle aches?

Yes or No

3) Can your child use hand sanitizer at camp? Yes or No

By signing this check in form I am stating that all of this information is true to the best of my knowledge. I understand that if my child has experienced any of these symptoms or develops any of these symptoms they will not be able to attend the After School Program for 72 hours or until the After School Program receives a written document from the child’s physician stating that they are able to attend.

Parent/Guardian’s Signature:___________________________ Date:_________