Tawasentha Day Camp

Daily Health Screening

Camper Name: _____ **Week of:** _____

Counselor Name (if accplicable) : _____

Assigned Group	K-1	2-3	4-5	MS	SN

	Monday	Tuesday	Wednesday	Thursday	Friday
Question 1:					
Within the past 14 days, has the camper tested positive for Covid-19?	Y / N ABS	Y / N ABS	Y / N ABS	Y / N ABS	Y / N ABS
Question 2:					
Within the past 14 days, has anyone in your household tested positive or was suspected of having COVID-19?	Y / N ABS	Y / N ABS	Y / N ABS	Y / N ABS	Y / N ABS
Question 3:					
Within the past 14 days, has anyone in your household been under mandatory or volunteer quarantine?	Y / N ABS	Y / N ABS	Y / N ABS	Y / N ABS	Y / N ABS
Question 4:					
Within the past 14 days, has the camper experienced any of the	ABS	ABS	ABS	ABS	ABS
Fever:	Y / N	Y / N	Y / N	Y / N	Y / N
Cough:	Y / N	Y / N	Y / N	Y / N	Y / N
Sore Throat:	Y / N	Y / N	Y / N	Y / N	Y / N
Diarrhea/Vomiting:	Y / N	Y / N	Y / N	Y / N	Y / N
Headache:	Y / N	Y / N	Y / N	Y / N	Y / N
Chest Pains:	Y / N	Y / N	Y / N	Y / N	Y / N
Muscle Pain:	Y / N	Y / N	Y / N	Y / N	Y / N
Loss of Taste or Smell:	Y / N	Y / N	Y / N	Y / N	Y / N
Shortness of Breath or Difficulty Breathing:	Y / N	Y / N	Y / N	Y / N	Y / N
Temperature Reading:					
Time of Temperature Reading:					
Initial of Person Completing Screening:					

Additional Notes:

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