Town of Guilderland Satellite Camp

Daily Intake Screening

Camper Name: _____ **Date:** _____

Instructor Name: _____

Has the camper recently had contact with anyone who has tested positive for Covid-19?	Is anyone in your household currently under mandatory or voluntary quarantine?	Is the camper experiencing any of the following symptoms:	
Y / N	Y / N	Fever:	Y / N
		Cough:	Y / N
		Sore Throat:	Y / N
		Diarrhea/Vomiting:	Y / N
		Headache:	Y / N
		Chest Pains:	Y / N
		Muscle Pain:	Y / N
		Loss of Taste or Smell:	Y / N
		Shortness of Breath or Difficulty	Y / N

Time of Daily Temperature Reading: _____

Initial of Person Completing Screening: _____

Additional Notes: _____

_____

_____

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Additional Notes: _____

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