Town Of Guilderland Sports/Enrichment Camp

Daily Intake Screening

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

Instructor Name: _____

	Monday	Tuesday	Wednesday	Thursday	Friday
Question 1: Has the camper recently had contact with anyone who has tested positive for Covid-19?	Y / N	Y / N	Y / N	Y / N	Y / N
Question 2: Is anyone in your household currently under mandatory or volunteer quarantine?	Y / N	Y / N	Y / N	Y / N	Y / N
Question 3: Is the camper experiencing any of the following symptoms:	Y / N	Y / N	Y / N	Y / N	Y / N
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 Taken at Home:					
Initial of Person Completing Screening:					
Initial of Program Instructor:					

Additional Notes:

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