Camper Name:

Contact Number:

Parent/Guardian Name:

Please answer the following questions and return the form to Chris Bruno:

1. Do you have any of these symptoms?

__ Cough	__Sore Throat
__Congestion or Runny Nose	__Loss of Taste or Smell
__Chills	__Digestive Problems
__Headache	__Shortness of Breath
__Muscle Pain	__Nausea or Vomiting

2. Is your temperature above 99.9 degrees Fahrenheit?
   __ Yes __No

3. Have you traveled outside of the contiguous United States?
   __ Yes __No

4. Have you been in close physical contact with anyone who has tested positive for COVID-19 in the past 10 days?
   __ Yes __No

5. Have you tested positive for COVID-19? If yes and cleared by the Department of Health (DOH) you may check off “no”.
   __ Yes __No

Parent/Guardian Signature:

Date: