COVID-19 DAILY CAMP CHECK-IN

Student’s Name: __________________________________________ Date: __________

You must be able to answer NO to every question to be allowed in class.

1. Have you traveled outside of the state or country in the last 14 days? YES  NO

2. If yes, what State? ______________________

3. Have you come in contact with ANYONE CONFIRMED COVID-19 POSITIVE in the last 14 days? YES  NO

4. Have you had any of the following symptoms in the last 14 days?
   - Fever? YES  NO
   - Cough? YES  NO
   - Shortness of breath? YES  NO

   TEMPERATURE: __________________

PARENT/GUARDIAN SIGNATURE: __________________________________________