Ndakinna Education Center

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: ____