girl scouts of black diamond

Attendee COVID-19 Screening Form

Attendee Name: _____ **Date:** _____

Screening Questions

1. Do you have a fever or above-normal temperature (>100F)? YES ___ NO ___
2. Have you taken fever reducers in the past 72 hours? YES ___ NO ___
3.Have you been experiencing shortness of breath or having trouble breathing? YES ___ NO ___
4. In the past 72 hours, have you had a dry cough? YES ___ NO ___
5. In the past 72 hours, have you had a runny nose? YES ___ NO ___
6. In the past 72 hours, have you had a sore throat? YES ___ NO ___
7. Have you recently lost or had a reduction in your sense of smell or taste? YES ___ NO ___
8. In the past 72 hours, have you had any other flu-like symptoms, such as gastrointestinal upset, headache, muscle pain or fatigue? YES ___ NO ___
9. In the past 72 hours, have you had chills or repeated shaking with chills? YES ___ NO ___
10.Have you been tested for COVID-19? YES ___ NO ___ If YES, date tested _____ & what is the result? ____ Positive ___ Negative ____Awaiting result
11.In the last 14 days, have you been in contact with someone who has a confirmed case COVID-19, under investigation for COVID-19 or a respiratory illness? YES ___ NO ___
12.In the last 14 days, have you traveled to any foreign country? YES ___ NO ___ If YES, where?_____
13. For caregivers of minors: Is your Girl Scout required to wear a mask? YES ___ NO ___