COVID 19 screening Form

This form must be completed to enter the program/building

Date: Time: _____

Name: _____

Symptoms

HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS THE PAST THREE DAYS?	**Yes**	**No**
Cough		
Shortness of breath or difficulty breathing		
Fever or chills		
Muscle pain or body aches		
Sore throat		
Headache		
Nausea or Vomiting		
Diarrhea		
Runny nose or Stuffy Nose		
Fatigue		
Recent loss of taste or smell		

Risk Factors

	Yes	**No**
Have you been directed to quarantine or isolate by the Rhode Island Department of Health or a healthcare provider in the past 14 days? **If so, when does/did your quarantine or isolation period end?**		
Have you been in close contact with anyone with COVID-19 or symptoms of COVID-19 in the past 14 days? **This is not a risk factor if:** **• You're fully vaccinated against COVID-19 (more than 14 days after final dose); OR** **• You've tested positive for COVID-19 in the past 90 days and completed your isolation period; OR** **• You've tested out of quarantine based on current requirements**		

Cleared to enter program: **YES** **NO**

Parent/Guardian signature: _____

AQUIDNECK ISLAND DAY CAMP 2021