CAMP MEROCKDIM, CHAMPION DC DAILY SCREENING

Please complete a separate screening for each individual

Name ____ DOB ___________ Date ____________

1. Have you knowingly been in close or proximate contact in the past 14 days with anyone who has tested positive for COVID-19 or who has or had symptoms of COVID-19. yes ☐ no ☐

2. Have you tested positive for COVID-19 in the past 14 days. yes ☐ no ☐

3. Have you experienced any symptoms of COVID-19 in the past 14 days. yes ☐ no ☐

I affirm that I have answered all questions above to the best of my knowledge.

Signature ____

If under 18, Parent or Guardian signature needed.

Parent/ Guardian signature ____