Adult Health Pre-Screening Form: 14 Days

Participant Name:_______________________________ Arrival Date/Session_________________

Contact Info: Email:__________________________________ Phone:__________________

If household member, name and relationship to participant: ______________________________

Please record your temperature daily and indicate if any of the following symptoms are present. If you have a fever of 100.4 or greater or are experiencing any of the symptoms listed below, please contact your doctor and notify your group coordinator and/or Camp ACCOVAC before coming.

Optional: Have you received the COVID-19 Vaccine? ___ Full Dose?__ Date of last or full dose__________

Known Symptoms of COVID-19

*new cough

*Shortness of breath/difficulty breathing

*Fever of 100.4 or greater

*Chills

*Muscle pain

*Sore throat

*New loss of taste or smell

*Nausea, vomiting, stomach ache

*Diarrhea

Please initial:

*I have not been around anyone with any of the listed symptoms or a diagnosis of COVID-19 in the 14 days before my arrival at Camp ACCOVAC. **Initial**________

*No one in my household has been sick or shown symptoms of COVID-19 in the 14 days before my arrival to Camp ACCOVAC. **Initial** ______

*I have adhered to our/my state's guidelines regarding COVID-19. **Initial** ________

Start date of temperature/symptom screening:____________

Day (until arrival):	14	13	12	11	10	9	8
Temperature/symptoms							
Day (until arrival):	7	6	5	4	3	2	1
Temperature/symptoms							

INDICATE Y (yes) N (no) for symptoms and list temperature

My signature indicates that I completed this health screening daily to the best of my ability. I understand that arriving at Camp ACCOVAC healthy is necessary for a safe experience for all those around me.

Signature: ___________________________________Date:_______