girl scouts of eastern pennsylvania

Attendee COVID-19 Screening Form

Attendee Name: _____ **Date:** _____

Troop #: _____ **Activity:** _____

Screening Questions apply to both Personal and Professional Contact

1. Do you have a fever or above-normal temperature (>100.4F)?	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. In the past 72 hours, have you been tested for COVID-19? If YES, date tested _____ & what is the result? ____ Positive ____Negative	YES ___ NO ___
11. In the last 5 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 ___

Parent/Guardian Name *(if participant is a minor)*:

please print_____

Parent/Guardian Signature: _____Date: _____