Health Survey

COMPLETE ONE SURVEY per person & give to your Event Leader.

Name of Guest or Staff Member (printed)_____ Date of Visit_____

Phone Number_____ Email Address_____

Has the individual named above had COVID vaccination shot(s)?_____

Date of 1st Shot_____ Date of 2nd Shot_____ **OR** Date of Johnson & Johnson Shot_____

Date of Booster Shot #1_____ Date of Booster Shot #2_____ Date of Booster Shot #3_____

Within the last 14 days, has the individual named above **traveled** nationally or internationally?_____

If yes, please list locations traveled to:_____

Answer with a Yes or No

_____ Within the last 14 days, has the individual named above had a cough, shortness of breath – not related to asthma, diarrhea, fatigue, headache, muscle aches, nausea, loss of taste or smell, sore throat, vomiting, etc.?

_____ Within the last 14 days, has the individual names above or any member of your immediate household been in close contact with a person who has been diagnosed with, or quarantined as a result of COVID-19?

Do you currently have any of the following symptoms – *that you don't typically have from other conditions, such as asthma, heart condition, etc.?* **CIRCLE your responses.**

YES	**NO**	fever or feeling feverish	**YES**	**NO**	chills or repeated shaking with chills
YES	**NO**	new persistent cough	**YES**	**NO**	fatigue
YES	**NO**	muscle aches or body aches	**YES**	**NO**	new persistent headache
YES	**NO**	sore throat	**YES**	**NO**	congestion or runny nose
YES	**NO**	nausea or vomiting	**YES**	**NO**	diarrhea
YES	**NO**	shortness of breath (can't talk without catching your breath or your chest feels tight)			
YES	**NO**	new loss of or change in sense of smell or taste			

NOTE: If you answered YES to any of the symptoms above, you may not come to camp at this time.

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Signature (of Adult Guest, Staff Member or Parent/Guardian) ***Date***