



BOY SCOUTS OF AMERICA®
CHESTER COUNTY COUNCIL

2020 Spook-O-Ree

FRIDAY EVENING COVID-19 Screening Questionnaire

COMPLETE WHEN PROVIDED, TURN BACK IN IMMEDIATELY FOR ADMISSION INTO CAMP.

Name: _____ (Circle one): Youth Adult

TYPE (circle one): PARTICIPANT STAFF Date: _____

YES NO Are you or anyone in your household experiencing symptoms of COVID-19 including fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea within the past fourteen (14) days?

YES NO Did you take any medications to lower a fever in the past 24 hours?

YES NO Have you had a positive test for COVID-19 infection within the past fourteen (14) days?

YES NO Have you been in close contact (within 6 feet for 10 minutes or more) with anyone who tested positive for COVID-19 in the past fourteen (14) days that you are aware of?

YES NO Have you traveled to any of the following states in the past 14 days? Alabama, Arizona, Arkansas, California, Florida, Georgia, Idaho, Iowa, Kansas, Louisiana, Mississippi, Missouri, Nevada, North Carolina, North Dakota, Oklahoma, South Carolina, Tennessee, Texas, Utah, and Wisconsin.

I acknowledge that the above information is true and correct to the best of my knowledge. Any person answering yes to any of the above questions will not be admitted or allowed to participate. I understand that these questions are intended to reduce the potential of, but cannot eliminate, exposure to COVID-19. I agree to contact the staff if this participant tests positive for COVID-19 within 14 days of attendance at this program

Signature of Person completing form: _____

Temperature Recorded: _____ Initials: _____