CHAZAK
DAY CAMP

Healthcare Screening

Name: ______________________________ **Date**: __________

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 ____

Have you tested positive for COVID-19 in the past 14 days?

Yes ____ No ____

Have you experienced any symptoms of COVID-19 in the past 14 days?

Yes ____ No ____

People with these symptoms may have COVID-19:

- 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
- Diarrhea

This list does not include all possible symptoms. CDC will continue to update this list as it learns more about COVID-19.

For Official use only **Temperature:** __________