# Camp Chofetz Chaim

## Daily Health Screening

| Official use only: |
|---|
| Temperature _____ |
| Time_____ |

Date _____

Camper's Name (print) _____

Circle the grade your son is entering - K 1 2 3 4 5 6 7 8 9 10

Bunk _____

**1.** Has your son developed ANY of the following **symptoms** of COVID-19 infection in the last ten (10) days?

| | Y | N |
|---|---|---|
| Fever or chills? | | |
| Fatigue? | | |
| Shortness of breath? | | |
| Cough? | | |
| Muscle or body aches? | | |
| Sore throat? | | |
| Unusual headache? | | |
| Diarrhea? | | |
| New loss of taste or smell? | | |
| Nausea or vomiting? | | |
| Congestion or runny nose? | | |
| Difficulty breathing? | | |

**2:** Has your son had a **positive test** for COVID-19 infection within the past ten (10) days?

Y/N _____

**3:** Within the last ten (10) days, has your son been within six (6) feet for longer than 15 minutes with someone who has a suspected or confirmed COVID-19 infection, *WITHOUT taking proper precautions* like wearing a mask and frequently washing your hands during this contact period?

Y/N _____