Apex Centre Camp Participant COVID-19 Screening Checklist

This form must be completed each day upon arrival. Completed forms must be returned to a Camp Counselor before reporting to assigned group.

Participant's Name (print): ____

Date: ______________________________________ Time: ____________________________________

Is the participant experiencing any of the following symptoms?	YES	NO
Cough	☐	☐
Shortness of breath	☐	☐
Chills	☐	☐
Repeated shaking with chills	☐	☐
Muscle Pain	☐	☐
Headache	☐	☐
Sore throat	☐	☐
Loss of taste or smell	☐	☐
Feel feverish or measures a temperature of 100° F or greater	☐	☐
Has come in close contact with a person who is lab confirmed to have COVID-19?	☐	☐

Temperature must measure below 100° F

Temperature: ____

Name of employee who performed temperature check: _______________________________________