Communicable Disease/COVID-19 Prescreening Questionnaire

please complete this form within 24 hours of attending the 2021 Fall Fellowship

Full Name: ________________________________(Print) Unit number: _____________

Date of birth: ___________________________________ Today's Date: _____________

Please respond to each question by checking yes or no:

Yes	No	
❐	❐	In the last 24 hours, have you had a fever at or greater than 100.4 F?

Do you have any of the following symptoms associated with COVID 19?

Yes	No		Yes	No	
❐	❐	Shortness of breath	❐	❐	Vomiting
❐	❐	Feeling itchy all over	❐	❐	Diarrhea
❐	❐	Sore throat	❐	❐	Cough
❐	❐	New loss of taste or smell	❐	❐	Chills

Yes	No	
❐	❐	Have you been diagnosed with COVID 19 or have you been told by your physician or a public health official in the past 14 days that you should self-quarantine due to a potential exposure to the virus?
❐	❐	Have you had a COVID 19 test in the last one (1) to three (3) days?
❐	❐	If yes, was the test negative OR
❐	❐	Is the test result pending?
❐	❐	Have you received a COVID 19 vaccine? If yes, which vaccine did you receive?

❐ Pfizer (Date of second vaccine: ________________________)

❐ Moderna (Date of second vaccine: ____________________)

❐ Johnson & Johnson (Date of vaccine: __________________)

The information I/we have provided is true and accurate and has been completed within 24 hours of arrival at Camp Barstow.

_________________________________ OR _________________________________

Participant Signature (18 & over) OR Parent/Guardian Signature