

Encore Creative Productions Summer Team Camps 2020 COVID-19 Questionnaire

Name: _____ Age: _____

Team Camp for: _____

Camp Start Date: _____ Camp End Date: _____
MM/DD/YYYY MM/DD/YYYY

Body Temperature on day prior to camp start date: _____ Date: _____

Have you had any fever in the past 14 days? _____ Yes _____ No

Have you had any body chills in the past 14 days? _____ Yes _____ No

Have you been coughing in the past 14 days? _____ Yes _____ No

Have you had any shortness of breath in the past 14 days? _____ Yes _____ No

Have you had any muscle pain chills in the past 14 days? _____ Yes _____ No

Have you had any loss of taste or smell in the past 14 days? _____ Yes _____ No

Have you had any nausea, vomiting, or diarrhea in the past 14 days? _____ Yes _____ No

Have you been seen by a doctor in the past 7 days? If so, for what? _____ Yes _____ No

Have you knowingly been in contact with anyone who tested positive for COVID-19 in the past 14 days? _____ Yes _____ No

Questionnaire Completion date: _____
MM/DD/YYYY

Signature: _____

Print Name: _____

