



COVID-19 Symptoms Screening Survey for Camping & Activities

- 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 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
 - 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
- Please take your temperature, and classify the reading based on the following categories:
 - ☐ Temperature less than 100.4
 - ☐ Temperature at or above 100.4

I, _____ (*name of participant*) understand that I have answered the above questionnaire to the best of my knowledge and truthfully. I also understand while the GNYC has done everything in their ability to ensure the health & safety of all participants and visitors, it does not mean there is no risk. I will do my part and keep 6 feet distance and wear a face covering when social distance cannot be maintained.

(*email address*)

(*phone number*)

(*Participant Signature/ Parent Guardian if under 18*) (*Date*)

