COVID- 19 RCC SCREENING FORM

	Do you have any of the following:	Please check Yes	or No
1	fever or chills	☐	☐
2	New cough	☐	☐
3	Shortness of breath or difficulty breathing	☐	☐
4	Fatigue	☐	☐
5	Muscle or body aches	☐	☐
6	New loss of taste or smell	☐	☐
7	Sore throat	☐	☐
8	Congestion or runny nose	☐	☐
9	Headache	☐	☐
10	Nausea or vomiting	☐	☐
11	Diarrhea	☐	☐

Date/Session:_____

Camper Name:_____

Parent Signature:_____