Family Self-Health Assessment for Three Harbors Council

Troop #_______ Pack #______ City/State _______________________________________

Name: ____

Have you tested positive for Covid-19?

YES NO

Have you had close contact with someone who has tested positive for Covid-19 in the last 14 days?

YES NO

Do you have a sore throat/cough?

YES NO

Do you have any shortness of breath, or difficulty breathing?

YES NO

Have you experienced loss sense of smell or taste in last 14 days?

YES NO

Have you experienced unexplained muscle fatigue, Fever or chills in last 14 days?

YES NO

Have you traveled on a plane/cruise ship or to a Covid-19 "hot spot" in the last 14 days?

YES NO

Or in contact with someone who has?

YES NO

All Family members attending Camp:

Name:	Parent/guardian or youth
____________________________	__________________________
____________________________	__________________________
____________________________	__________________________
____________________________	__________________________
____________________________	__________________________

All persons in the car have answered "no" to the Heath assessment questions above:

Parent's Signature: _____________________________________ Date: __________