



COVID-19 Symptom Checklist for Group Activities

Scout Name: _____

Date: _____

Screened by: _____

Temperature: _____

In the last 14 days have you had any of the following:	Yes	No
Cough		
Shortness of Breath or Difficulty Breathing		
Fever		
Chills		
Muscle Pain		
Sore Throat		
New Loss of Taste or Smell		
Nausea, Vomiting, or Diarrhea		
Close contact with individuals diagnosed with COVID-19		



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