girl scouts
of the desert southwest
southern new mexico
and west texas

Attendee COVID-19 Screening Form

Attendee Name: _____ **Date:** _____

Parent/Guardian Name: _____ **Signature:** _____

Screening Questions apply to both Personal and Professional Contact

Please reference the In-person Guidance document if someone answers **YES** to any of the questions bleow.

1. Do you have a fever or above-normal temperature (>100F)?	YES ___ NO ___
2. Have you taken fever reducers in the past 24 hours?	YES ___ NO ___
3. Have you experienced shortness of breath or having trouble breathing?	YES ___ NO ___
4. In the past 72 hours, have you had a dry cough?	YES ___ NO ___
5. In the past 72 hours, have you had a runny nose?	YES ___ NO ___
6. In the past 72 hours, have you had a sore throat?	YES ___ NO ___
7. Have you recently lost or had a reduction in your sense of smell or taste?	YES ___ NO ___
8. In the past 72 hours, have you had any other flu-like symptoms, such as gastrointestinal upset, headache, muscle pain or fatigue?	YES ___ NO ___
9. In the past 72 hours, have you had chills or repeated shaking with chills?	YES ___ NO ___
10. Have you been tested for COVID-19? If YES, date tested _____ & what is the result? ____ Positive ___Negative ____Awaiting result	YES ___ NO ___
11. In the last 14 days, have you been in contact with someone who has a confirmed COVID-19 case, under investigation for COVID-19 or a respiratory illness?	YES ___ NO ___