

**Town of Camillus Dept of Parks & Recreation
PARTICIPANT/SPECTATOR HOME SCREENING QUESTIONS**

DATE: _____ Name: _____

Temperature was checked this morning and it was less than 100.00F

In the last 14 days, my child/myself **HAS NOT:**

Experienced ANY of the following symptoms of COVID-19
(Fever - 100.0 F or greater; Chills; 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)

Tested positive through a diagnostic test for COVID-19.

Knowingly been in close or proximate contact with anyone who has tested positive through a diagnostic test for COVID-19 or who has had symptoms of COVID-19.

Traveled internationally or from a state with widespread community transmission of COVID-19 per the New York State Travel Advisory.

I attest that the above are true on this date.

Parent/Spectator Signature _____
a separate form must be filled out for each individual.

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