girl scouts
usa girl scouts
overseas

USAGSO Attendee COVID-19 Screening Form

Attendee Name: _____ Date:_____

Do you have a fever or above normal temperature (> 100 F)?	**Yes**	**No**
Have you taken fever reducers in the past 72 hours?	**Yes**	**No**
Have you been experiencing shortness of breath or having trouble breathing?	**Yes**	**No**
In the past 72 hours, have you had a dry cough?	**Yes**	**No**
In the past 72 hours, have you had a runny nose?	**Yes**	**No**
In the past 72 hours, have you had a sore throat?	**Yes**	**No**
In the past 72 hours, have you had any other flu-like symptoms, such as gastrointestinal upset, headache, muscle pain or fatigue?	**Yes**	**No**
In the past 72 hours, have you had chills or repeated shaking with chills?	**Yes**	**No**
Have you recently lost or had a reduction in your sense of taste or smell?	**Yes**	**No**
Have you been tested for COVID -19? If yes, date tested _____& what result: _____Positive _____Negative _____Awaiting results	**Yes**	**No**
In the last 14 days, have you been in contact with someone who has a confirmed case of COVID-19, under investigation for COVID-19 or a respiratory illness?	**Yes**	**No**
In the last 14 days, have you traveled to another country? If yes, where? _____	**Yes**	**No**

Please keep this form in a confidential location for 2 months following the event. After that time this form can be discarded in a manner that protects the person's privacy.