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 an unexplained 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

All Family members attending event:

Name:	Parent/Guardian/Youth/Leader	Temperature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Parent’s Signature: _____ Date: _____