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Adventureland COVID Questionnaire

**Family Name:**

Has anyone in your family been in close physical contact with a person experiencing symptoms of COVID-19 such as shortness of breath, dry cough, fever, flu-like symptoms, etc within the past 14 days?

* Yes
* No

Have you, or anyone in your household, been in contact with anyone that has tested positive for COVID-19 in the last 14 days?

* Yes
* No

Have you or anyone in your family travelled out of the country in the last 14 days?

* Yes
* No

Has anyone in your family experienced any new or worsening cold or flu-like symptoms in the last 14 days (to include fever, cough, sore throat, respiratory illness, difficulty breathing?

* Yes
* No

Child’s Name: Temp: Age:

Childs’s Name: Temp: Age:

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