TELLURIDE ACADEMY

Daily COVID-19 Student Health Screening

Student Name: _____
Name of Program:_____
Program Instructors:_____ **&** _____

In the last 24 hours, have you experienced any of the following symptoms? (Y/N)

Date	Cough	Fever	Headache	Mscl Pain	Sore Throat	Chills	Loss taste/smell	Shortness breath	Temp ^{o}F

If temperature is between 99.2 and 100.3, monitor throughout the day. If temperature is 100.4 or higher, child must be excluded from camp.

Does your child have any underlying conditions? If yes, please explain:

_____

_____

Does your child share a home with an individual considered "high risk" to exposure to the Covid-19 virus (heart condition, respiratory condition, etc) ? If yes, please explain:

_____

_____

Has your child recently traveled out of the county? If so, for how long?

_____

_____

Are you visiting or living in Telluride for the summer?_____
If so, on what date did you arrive to the county? _____
Did you implement a 14-day quarantine upon arrival?_____