

Kaiserman JCC – Coronavirus (COVID-19) Entry Screening Form

Name (Please Print): _____

Arrival Time and Date: _____

- In the past 24 hours has your child experienced any of the following COVID-19 symptoms: Fever or felt feverish, cough, shortness of breath/trouble breathing, muscle soreness, sore throat, sudden changes in taste or smell, runny nose, headaches, or diarrhea? Yes No
- Is anyone in your household experiencing any of the above symptoms? Yes No
- Have you had contact with anyone diagnosed with COVID-19 in the last 14 days? Yes No
- Have you travelled outside PA to a state on the Commonwealth’s Travel Restriction list within the last 14 days Yes No

Signature: _____

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