COVID-19 Screening Verification Form

School:	Program Dates:

	First Name	Last Name	Participant Type Student, Cabin Leader, or Classroom Teacher	Check if: Symptom free & fever free for 24 hours w/o medication	Check if: Participant had positive test in last 30 days and 5 days have passed since first positive test or start of symptoms, and they have since tested negative.
1					
2					
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Signature of School Staff Member Verifying Results: _____