Restoration Students Shine On Beach Camp 2020
Verification Form

We are excited about conducting our own camp at the Gulf Shores Beach Retreat this year. In order to provide a safe and healthy camp environment this summer please complete this **verification form**, which is required and should be filled out and signed before your child can attend camp. *(Note: The information on this form is strictly confidential for church staff only)*

Child's Name (please PRINT) _____

1	**Are you experiencing any of the following symptoms?** • Fever • New onset or worsening of cough or other symptoms • Sneezing/Running Nose • Sore throat • Difficulty breathing • Severe Fatigue • Loss of taste or smell • Unexplained rashes • Significant and unexplained muscle pain • Vomiting or diarrhea	☐ Yes ☐ No
2	**Have you been without a fever for at least 72 hours (that is three full days of no fever without the use of medicine that reduces fevers, such as aspirin, Advil, Tylenol, naproxen sodium, etc.)?**	☐ Yes ☐ No
3	**Have you ever received a positive test for COVID-19?** **(If "Yes," please answer 3a-c, otherwise go to 4)**	☐ Yes ☐ No
3a	**If you have symptoms, have they been improving, staying the same, or worsening?** ☐ Improving ☐ Staying the same ☐ Worsening ☐ No known symptoms	
3b	**Have at least 10 days passed since the onset of symptoms?**	☐ Yes ☐ No
3c	**If you have had no known symptoms, has it been at least 10 days since the date your positive COVID-19 test was taken?**	☐ Yes ☐ No
4	**Have you travelled more than 100 miles from your home within the last 14 days, or have you had close contact with a person who travelled more than 100 miles from home in the last 14 days who has become ill (cough, fever, sneezing, or sore throat)?**	☐ Yes ☐ No
5	**Did you provide care or have close contact with a person with COVID-19 (potential or confirmed) while they were ill (cough, fever, sneezing, or sore throat) within the last 14 days?**	☐ Yes ☐ No
6	**Have you or anybody in your home had contact with someone who has been diagnosed with COVID-19 within the last 14 days?**	☐ Yes ☐ No
7	**Have you received a confirmed negative COVID-19 test?** **(If so, date of most recent test: _____.**	☐ Yes ☐ No

Signature _____ Date_____