BEAR MOUNTAIN SKI HILL COVID 19 DAILY QUESTIONAIRE

1) ARE YOU EXPERIENCING ANY NEW OR WORSENING SYMPTOMS? *

* *Do not answer yes for known pre-existing conditions that display COVID 19 like symptoms.*

	YES	NO
FEVER OR CHILLS	O	O
SORE THROAT OR PAINFUL SWALLOWING	O	O
MUSCLE ACHES OR FATIGUE	O	O
COUGH	O	O
DIFFICULTY BREATHING	O	O
LOSS OF SENSE OF TASTE OR SMELL	O	O
NAUSEA, VOMITING OR DIARRHEA	O	O
HEADACHE	O	O
LOSS OF APPETITE	O	O
RUNNY OR STUFFY NOSE	O	O

2) IN THE LAST 14 DAYS, HAVE YOU:

a) BEEN ADVISED TO SELF ISOLATE OR QUARANTINE AT HOME BY PUBLIC HEALTH OR BORDER SEVICES? O O

b) BEEN IN CLOSE CONTACT WITH SOMEONE WHO HAS CONFIRMED POSITIVE FOR COVID 19? IE. WITHIN 6 FEET FOR MORE THAN 15 MINUTES CUMULATIVE WITHIN A 24 HOUR PERIOD. O O

NAME: _____ PHONE # _____

DATE _____

SIGNED _____ TIME ARRIVED _____