		BEAR MOUNTAIN SKI HILL COVID 19 DAILY QUESTIONAIRE						
		ONE PER FAMILY						
	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 , MUSCLE ACHES, FATIGUE, COUGH, RUNNY OR STUFFY NOSE					O	O
		DIFFICULTY BREATHING, LOSS OF SENSE OF SMELL OR TASTE, LOSS OF APPETITE					O	O
		NAUSEA, VOMITING OR DIARRHEA, HEADACHE					O	O
	2)	IN THE LAST 14 DAYS, HAVE YOU:						
	a)	BEEN ADVISED TO SELF ISOLATE OR					O	O
		QUARANTINE AT HOME BY PUBLIC HEALTH OR						
		BORDER SEVICES?						
	b)	BEEN IN CLOSE CONTACT WITH SOMEONE					O	O
		WHO HAS CONFIRMED POSITIVE FOR COVID 19?						
		IE. WITHIN 6 FEET FOR MORE THAN						
		15 MINUTES CUMULATIVE WITHIN A 24 HOUR PERIOD.						
		NAME: _____ PHONE #_____ DATE_____						
		# OF FAMILY MEMBERS_____						