Health Screening

Parent ___________________________

Camper___________________________

Session/Yr_______________________

1. **Have you/any of your immediate family members had close contact with or cared for someone diagnosed with COVID-19 (coronavirus) within the past 14 days?**

   ☐ YES (explain on back) ☐ NO

2. **Have you/anyone in your immediate family experienced a fever over 100 or had pneumonia within the past 14 days?**

   ☐ YES (explain on back) ☐ NO

3. **Have you/camper had any evidence of or exposure to the following in the past 14 days?** *Please check all applicable items and explain or circle none.*

☐ Contagious Disease	☐ Headache
☐ Stomachache	☐ Nausea
☐ Vomiting	☐ Diarrhea
☐ Fever	☐ Body Ache
☐ Lice	☐ Bed Bugs
☐ Breathing Problems	☐ Respiratory Illness

☐ NONE

If you have answered yes to questions 1 or 2 please stay home and call the camp office for further details regarding your account.

Please use the back of this form for any other information or explanation.

Temp. at Check-in	Screened by Initials

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Camper___________________________

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