Health Screening Form

Camper/Staff Name: _____ Camp Name: _____ Camp Program #: _____

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
	Temp. _____	Temp. _____	Temp. _____	Temp. _____	Temp. _____
Is your child currently experiencing any breathing difficulty, coughing, sore throat, fever or chills, fatigue, muscle or body aches, headache, loss of taste or smell, congestion or runny nose, nausea or vomiting, or diarrhea?	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____
Is your child currently taking any medication for any of these symptoms?	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____
In the past 14 days has your child come in direct contact with anyone who has tested positive for covid-19 or has symptoms consistent with covid-19 symptoms?	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____
Has your child tested positive for covid-19 in the last 14 days?	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____
Is your child isolating or quarantining because they might have been exposed to someone with covid-19 or are they worried they might be sick with covid-19?	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____
Is your child awaiting results of a covid-19 test?	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____	Yes or No Comments: Initial _____