Day Camp Initial Camper Health Screen Form
Must be filled out and brought to check-in on Monday morning.

Camper Name_____ Date_____

Temperature _____ Obtained by _____ (Initial)

Has your child shown any of the following contagious symptoms in the last two weeks?

Symptoms	**Yes**	**No**
Oral temperature over 100 degrees F		
Flu or flu-like symptoms (fever, cough, sore throat)		
Sore throat with fever		
Vomiting		
Diarrhea		
Severe headache accompanied by stiff neck		
Inflamed, bloodshot eyes with discharge		
Unusually dark, tea-colored urine		
Yellowish eyes or skin		
Grayish or white stools		
Severe itching of body or scalp		
Infected skin patches		

Has your child been exposed to anyone with COVID 19 or influenza-like illness (fever >100ºF, cough, sore throat) during the past 2 weeks?
Yes _____ No _____

Has your child been exposed to any other known contagious disease in the last two weeks?
Yes _____ No _____

Has your child had any recent injuries that would prevent them from participating in any camp activities?
Yes _____ No _____

Does your child have any healing injuries, open cuts/sores or severe bruises?
Yes _____ No _____

Does your child have any prescription medications, vitamins, or over-the-counter drugs to turn into the nurse?
Yes _____ No ____

*If **Yes** was answered to any of the questions above, please describe.*

Parent/Guardian, Please sign the below to verify completion of Camper Health Screening Form.

PARENT OR GUARDIAN SIGNATURE _____ **DATE** _____

Reviewed on: _____ Initials: _____

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