## Health Screening

Camper Name: _____

Has your **CAMPER** or **ANY MEMBER OF YOUR IMMEDIATE FAMILY**:

| Yes | No | | |
|---|---|---|---|
| ☐ | ☐ | 1. | Been exposed to a communicable disease (such as chicken pox, pink eye, ringworm) in the last two weeks? |
| ☐ | ☐ | 2. | Had a cough, cold, runny nose or sore throat in the past 48 hours? |
| ☐ | ☐ | 3. | Experienced nausea, vomiting, and/or diarrhea in the past 24 hours? |
| ☐ | ☐ | 4. | Had a fever of 100° F or greater in the past 24 hours? |
| ☐ | ☐ | 5. | Has complained of abdominal pain or headache in the past 24 hours? |
| ☐ | ☐ | 6. | Currently has or been exposed to or treated for head lice in the last 7 days? |
| ☐ | ☐ | 7. | Has a rash or skin irritation in the last 7 days? |
| ☐ | ☐ | 8. | Had a seizure in the past. Date of last seizure _____ |
| ☐ | ☐ | 9. | Allergic to food, medication, and/or seasonal irritants (dust, mold, pollen)? |
| ☐ | ☐ | 10. | Brought or is presently taking medication? |
| ☐ | ☐ | 11. | Has a medical condition/diagnosis not requiring medication? |

If there are any boxes checked yes, you will need to see the Camp Nurse.

Parent Signature: _____

Date: _____ ☐ Check here if tetanus shot **NOT** up to date


## Health Screening

Camper Name: _____

Has your **CAMPER** or **ANY MEMBER OF YOUR IMMEDIATE FAMILY**:

| Yes | No | | |
|---|---|---|---|
| ☐ | ☐ | 1. | Been exposed to a communicable disease (such as chicken pox, pink eye, ringworm) in the last two weeks? |
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If there are any boxes checked yes, you will need to see the Camp Nurse.

Parent Signature: _____

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