PROUD PARTNER OF Camp Twin Lakes
Where Challenges Become Triumphs

PRE-CAMP HEALTH SCREENING

Family Name _____

Number Attending _____

Dear Camp Families,
In an effort to minimize illness at camp we ask that you check on the health of each family member attending Family Camp daily beginning 14 days prior to camp. The best camp sessions start with healthy campers and this begins at home. Please have this form ready for presentation as you enter the gates of camp.

Please indicate if anyone in your family has any of the following symptoms prior to camp and record the temperature daily. If any temperature or symptoms are present, please have that family member evaluated by a licensed provider and contact your Camp Director for further guidance.

Symptoms:

- Cough
- Shortness of breath or difficulty breathing
- Fever
- Chills
- Muscle Pain
- Sore Throat
- New loss of taste or smell
- Nausea
- Vomiting
- Diarrhea

Please Initial

1. My family has not been around anyone with any of the listed symptoms or diagnosed of COVID-19 in the 14 days before the start of camp. Initial _____
2. No one in our household has been sick in the 14 days prior to camp. Initial _____
3. My family has not traveled by air or traveled out of state in the 14 days prior to camp. Initial _____
4. My family has adhered to our state's guidelines regarding COVID-19. Initial _____

Start Date of Temp Screening:

_____

Day Temp/Symp			
1.	2.	3.	4.
5.	6.	7.	8.
9.	10.	11.	12.
13.	14.		

Example: 98.6, 98.2, 98.9, 99.1 No Symp

Our signature indicates that we completed this health screening daily for 14 days prior to camp and to the best of our ability. We understand that arriving to camp healthy is vital to a healthy camp for all families.

Signature: _____ **Date:** _____

Admin Use Only At Camp

Temperature of Each Family Member at Arrival

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Please ask all these questions to the family after temperature check:

- Are you or your family currently experiencing, or have you experienced in the past 14 days, any of the following symptoms?

  Y___ N___ Fever (100.4' F/ 37.8' C or greater as measured by an oral thermometer)
  Y___ N___ Cough
  Y___ N___ Shortness of breath or difficulty breathing
  Y___ N___ Sore Throat
  Y___ N___ New Loss of taste or smell
  Y___ N___ Chills
  Y___ N___ Head or muscle aches
  Y___ N___ Nausea, diarrhea, vomiting

- In the past 14 days, have you or your family been in close proximity to anyone who was experiencing any of the above symptoms or has experienced any of the above symptoms since your contact?

  Y___ N___

- In the past 14 days, have you or your family been in close proximity to anyone who has tested positive for COVID-19?

  Y___ N___

- Have you or your family been tested for COVID-19 and are waiting to receive test results?

  Y___ N___

- Have you or your family tested positive for COVID-19, or are you presumptivelly positive for COVID-19 based on your health care provider's assessment of your symptoms?

  Y___ N___

- In the past 14 days, have you or your family been on a commercial flight or traveled outside of the United States?

  Y___ N___

- Is there any reason why you or a family member feel you are at higher risk of contracting COVID-19 or experiencing complications from COVID-19 by entering the facility? If "yes", please provide a brief explanation.

  Y___ N___

  Explain:

Screener Initial: _____

Family Initial: _____

Date & Time of Arrival: _____