SWC Camper Health Screening

Date_____

Camper Name: _____Temperature (pass/fail): _____
Fail is temp over 100.4, if fail camper should go home
Camp: _____

Are you currently experiencing, or have you experienced in the past 14 days, any of the following COVID-19 symptoms?

- Fever (100.4 degrees or greater)
- Cough
- Shortness of breath or difficulty breathing
- Sore throat
- New loss of taste or smell
- Chills
- Head or muscle aches
- Nausea, diarrhea, vomiting

Yes ○ No ○

Has anyone in your household shown signs of a fever or cold symptoms in the last two weeks?

Yes ○ No ○

Have you come into contact with anyone that has tested positive for COVID-19?

Yes ○ No ○

If Individual answers yes to any question they will not be allowed on Camp.

Camper Signature; _____ Date _____