CAMPER AT Camp Health Screening

Name: _____ Cabin #: _____.

Allergies: _____ Temperature _____ Date/Time _____

Please answer the following questions to protect our camp community from a contagious illness.

RECENT ILLNESS: Have you had any of the following symptoms in the past 48 hours?

Pink Eye	YES	NO	DIARRHEA?	YES	NO
FEVER?	YES	NO	OPEN SORES?	YES	NO
VOMITING?	YES	NO	RASH?	YES	NO
Coughing?	YES	NO	BUG BITES?	YES	NO
W/ blood?	YES	NO		If yes, ask about bed bugs.	

RECENT EXPOSURE: Have you been exposed to the following conditions in the past 48 hours?

- Person with any of the above symptoms YES NO If yes, who?
- Person with Chicken Pox YES NO
- Person with tuberculosis TB YES NO

PHYSICAL SCREENING

- Head Lice (live or nits) YES NO
- Physical Injury (observable) YES NO
- Unexplained weight loss (10 lbs.) YES NO
- Unexplained extreme weakness or fatigue? YES NO
- Unexplained chest pains? YES NO

MEDICAL HISTORY

- Have all the medications been received and stored? YES NO
- Any changes to the volunteer health history? YES NO If yes, change the health form
- Are there Over The Counter (OTC) medications? YES NO If yes, change the health form

TUBERCULOSIS SCREENING

- Have you been hospitalized within the last month? YES NO
- Have you been given BGC vaccines (given outside the US)? YES NO
  BCG **vaccine** provides immunity or protection against tuberculosis (TB)
- Have you ever tested positive for TB? YES NO
  - If yes, chest x-rayed?
  - Medication?
- Do you have a family member with TB? YES NO

NAME of SCREENER* _____ **VOLUNTEER'S INITIALS*** _____

***Information is accurate to the best of my abilities.**

5/2022