

HEALTH SCREENING FORM: LABCC CAMP MORNING STAR

Arrival Date _____ Departure Date _____ Camper Staff

Participant Name: _____
Last First

Health screening of campers and staff is critical to prevent an illness outbreak from starting. Per Title 17, Section 30750 of the California Code of Regulations, screening shall be conducted by a qualified staff member for all campers under the age of 18 who are unaccompanied by a parent or guardian within 24 hours of arrival at camp. It is recommended, prescreening of campers and staff be done prior to arriving at camp to prevent the spread of illness. Records of health screenings and procedures must be maintained at the camp.

No	Yes	1. Has participant been exposed to any known contagious disease in the <u>past 10 days</u>? If yes, please explain:
<input type="checkbox"/>	<input type="checkbox"/>	

2. Has participant shown, or been in contact with others who exhibited, any of the following symptoms within the <u>past 24 to 48 hours</u> prior to camp arrival?					
No	Yes		No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	Fever (temp > 100.3°F) or Chills	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath or difficulty breathing
<input type="checkbox"/>	<input type="checkbox"/>	Nausea or Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Weakness or fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Muscle or body aches
<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	New loss of taste or smell
<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Rash
<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Severe itching of body or scalp
<input type="checkbox"/>	<input type="checkbox"/>	Sneezing, congestion or runny nose	<input type="checkbox"/>	<input type="checkbox"/>	Open draining sore on skin
_____ Signature (Parent/Guardian if participant under 18 years old) Date					

No	Yes	3. Does participant have any cold/flu-like symptoms (in BOLD above) on first day of camp? If yes, please complete COVID-19 antigen test in the morning prior to arrival.
<input type="checkbox"/>	<input type="checkbox"/>	
No	Yes	4. Has participant been diagnosed with COVID-19 within the <u>past 10 days</u>? If yes, list date: _____ If yes, must be symptom free and have 2 negative results for COVID-19 antigen tests 24 hours apart.
<input type="checkbox"/>	<input type="checkbox"/>	

Pre-Arrival COVID-19 Home Antigen Testing Results (only required if answer YES to Question #3 or #4 above)	
Test #1 - Day of Arrival (only required if answer YES to Question #3 or #4 above) Date: _____ Time: _____ Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive	Test #2 - 24 hours prior to Test #1 (only required if answer YES to Question #4 above) Date: _____ Time: _____ Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive

TO BE COMPLETED BY LABCC STAFF ONLY	
Result of Health Screening: <input type="checkbox"/> Attend camp <input type="checkbox"/> Schedule f/u antigen test on date: _____ <input type="checkbox"/> Quarantine at camp in the isolation area <input type="checkbox"/> Send home / did not attend camp	
_____ LABCC Health Supervisor Signature	