Camp Betsey Cox Arrival Wellness Check

Camper Name: **Date:** ______________

Age: **Grade:** **Allergies:**

(circle if applicable: Food, Environmental, Med)

Meds: Yes No (please circle)

In the past 7 days have you had:	Arrival Day		Notes:
	yes	no	
Cough			
Difficulty Breathing			
Fever (feeling feverish or temp above 100.5F)			
Chills			
Repeated shaking with chills			
Muscle or body aches			
Headache			
Sore Throat			
New loss of taste or smell			
Congestion or runny nose			
Nausea or vomiting diarrhea			
Exposure to Covid 19			
Contact with anyone with COVID-19 symtoms			
Vaccinated?			
	Date:		
	Initials:		

Lice Check YES NO

Parent/Guardian Printed Name: ____________________________________ **Camper Printed Name:** ____________________

Parent/Guardian Signature: ____________________________________ **Camper Signature:** ________________________