



Camp Betsey Cox Arrival Wellness Check

Camper Name: _____

Date: _____

Age: _____ **Grade:** _____

Allergies: _____

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 100.4F)			
Chills			
Repeated shaking with chills			
Muscle or body aches			
Headache			
Sore Throat			
Rash			
New loss of taste or smell			
Congestion or runny nose			
Nausea or vomiting diarrhea			
Exposure to any communicable illness (Measles, Strep, Covid, Chicken Pox)			
Flu symptoms within 48 hours			
Vaccinated for Covid 19?			
Vaccinated for Measles?			
	Date:		
	Initials:		

Lice Check

--	--

Parent/Guardian Printed Name: _____

Camper Printed Name: _____

Parent/Guardian Signature: _____

Camper Signature: _____