



## Camp Betsey Cox Wellness Check- Arrival

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Allergies: \_\_\_\_\_

(circle if applicable: Food, Environmental, Med)

Meds: Yes No (please circle)

In the past 7 days have you experienced?	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			
New loss of taste or smell			
Congestion or runny nose			
Rash or skin irritation			
Nausea or vomiting diarrhea			
Exposure to any communicable illness?			
Covid, Flu, RSV, Strep, Measles, chicken pox, other (please add note)			
Vaccinated with usual childhood vaccines?			
includes: DTaP, Tdap, MMR see HF.1 page 2.			
	Date:		
	Initials:		

Lice Check YES NO

Printed Name: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_