MEDICAL SCREENING

To be filled out by a parent or guardian at the time of screening

NAME:_____ WARD:_____ LEVEL:_____

1. Any **new** allergies?	NO	YES
2. Any **new** restrictions?	NO	YES
3. Any medications coming up to camp? (If so, complete the MEDICATION FORM and submit medications in their original containers to the nurse during the medical screening)	NO	YES
4. Are there any **rashes, open wounds or sores**?	NO	YES
5. Do you have **Athlete's foot**?	NO	YES
6. In the past **48 hours**, any exposure to **Pink Eye** or **Strep Throat?**	NO	YES
7. Any **fever** in the past **48 hours**?	NO	YES
8. Any **diarr**hea or **vomiting** in the past **48 hours**.	NO	YES
9. Any exposure to **head lice** in the past **48 hours**.	NO	YES
10. Are there any chronic or **recurring conditions that mimic COVID-19 symptoms** (like headaches, allergies with a running nose, etc). **Please explain on the back**.	NO	YES
11. In the past 14 days, any exposure to COVID-19, or any symptoms of COVID-19? (Such as fever, cough, shortness of breath, loss of taste/smell, sore throat, muscle aches, vomiting, diarrhea)	NO	YES
12. Any other medical or health issues or changes not previously mentioned?	NO	YES

If there are any changes at this time, please let your ward or stake camp leaders know immediately. **IF A YOUNG WOMAN HAS ANY SYMPTOMS OF ILLNESS WHILE AT CAMP, THEY WILL BE SENT HOME.**

_____ _____ _____

Parent/Guardian Name Parent/Guardian Signature Date

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FOR NURSE USE ONLY

Comments

Throat/Strep	_____
Head Lice	
Pink Eye	_____

CURRENT TEMP

_____ _____ _____

Nurse/Adult Leader Name Nurse/Adult Leader Signature Date