2020 Camp Wabanna Health Screening Questionnaire

Name of Camper (please print) _____

Communicable Illness Assessment
In the last 14 days has your camper: 1. Come into contact with a known case of Covid-19? ___Yes ___No 2. Experienced the following symptoms: a. Fever (100.4F or greater)? ___Yes ___No b. Shortness of breath? ___Yes ___No c. Cough? ___Yes ___No d. New loss of taste or smell? ___Yes ___No 3. Traveled to an area that has been declared a "hot spot" for COVID-19? ___Yes ___No If yes explain: _____

By signing below, I certify that I have completed this form with the utmost honesty. I agree to keep my camper at home if I have answered yes to any of the above questions.

Parent/Guardian Signature_____ **Date**_____

Print Parent/Guardian Name_____

Please bring completed form with you to check-in.