



Youth Health Pre-Screening Form: 7 Days + Negative PCR Test

Participant Name: _____ Arrival Date/Camp Session: _____

Contact Info: Email: _____ Phone: _____

If household member, name and relationship to participant: _____

Please record your temperature daily and indicate if any of the following symptoms are present. If you have a fever of 100.4 or greater or are experiencing any of the symptoms listed below, please contact your doctor and notify your group coordinator and/or Camp ACCOVAC before coming.

Optional: Has camper received the COVID-19 Vaccine? ___ Full Dose?___ Date of last or full dose _____

Known Symptoms of COVID-19

- *new cough
- *Shortness of breath/difficulty breathing
- *Fever of 100.4 or greater
- *Chills
- *Muscle pain
- *Sore throat
- *New loss of taste or smell
- *Nausea, vomiting, stomach ache
- *Diarrhea

Please initial:

*My child has not been around anyone with any of the listed symptoms or a diagnosis of COVID-19 in the 7 days before their arrival at Camp ACCOVAC.

Initial _____

*No one in our household has been sick or shown symptoms of COVID-19 in the 7 days before my child's arrival to Camp ACCOVAC. **Initial** _____

*We have adhered to our/my state's guidelines regarding COVID-19. **Initial** _____

Start date of temperature/symptom screening: _____

Day (until arrival):	14	13	12	11	10	9	8
Temperature/symptoms							
Day (until arrival):	7	6	5	4	3	2	1
Temperature/symptoms							

INDICATE Y (yes) N (no) for symptoms and list temperature

Date of PCR/Molecular/72 hour COVID-19 test: _____ Please bring a copy of your negative test result to show to Camp ACCOVAC staff at check-in.

My signature indicates that we completed this health screening daily to the best of our ability. I understand that arriving at Camp ACCOVAC healthy is necessary for a safe experience for all those around me/them.

Signature: _____ **Relationship to Camper:** _____ **Date:** _____