NEW LIFE RANCH

# MEDICAL SCREENING *for Entering Camp*

**Travel/Contact History:**

Have you traveled to or had contact with an individual who has traveled to a foreign country in the last 21 days? **Y or N**

If yes, please explain: _____

Have you had close contact with someone exposed to or infected with COVID-19 in the last 21 days? **Y or N**

If yes, please explain: _____

Is a member of your household currently on a watch list for COVID-19 exposure or currently infected with COVID-19? **Y or N**

**Symptoms:** Have you had any of the below symptoms in the past 21 days?

___ Fever (above 100.4 degrees F) **Current Temperature _____** ___ Cough ___ Shortness of Breath ___Chills

___Repeated shaking with chills ___Muscle pain ___Headache ___Sore Throat ___New loss of taste or smell

___ **NO SYMPTOMS**

**Risk Factors:** Do you have any of the risk factors listed below?

___ Moderate to Severe Asthma ___ Diabetes ___ Chronic lung disease

___ Serious heart conditions ___ Severe Obesity ___ Other serious underlying medical conditions

___ Currently taking immunosuppressive medications (chemotherapy, corticosteroids, etc.)

___ Immunocompromised (immunodeficiency, bone marrow or organ transplant, cancer treatment, smoking, etc.)

***This report and any other medical information provided will be kept confidential in the camp office.***