II COR. 5:17

NEW LIFE RANCH

MEDICAL SCREENING *for Entering Camp*

NAME DATE

Travel/Contact History:

Have you traveled to or had contact with an individual who has traveled to a foreign country in the last **14** 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 **14** days? **Y or N**

If yes, please explain: _____

Is a member of your household currently in quarantine due to 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**

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