JENNESS PARK CHRISTIAN CAMP HEALTH SCREENING FORM

CAMP DATES______________________

CAMPER'S NAME:____

AGE:____________________________ **DATE OF BIRTH:**______________________ **SEX: M / F**

CHURCH/CITY:____

PARENT/GUARDIAN'S NAME AND PHONE:____

IF YOU OBSERVE ANY ILLNESS, COMMUNICABLE (INFECTIOUS) DISEASE, OR INJURY AS LISTED BELOW IN THE THREE BOXES, DESCRIBE THE ITEM THAT WAS CIRCLED ON THE LINES PROVIDED BELOW.

A.	B.	C.
ILLNESS (in the last 48 hours) **MAY INCLUDE:** NAUSEA, VOMITING, DIARRHEA, FEVER, SORE THROAT, RASH, OPEN SORES, PINK EYE, **COUGH NOT RELATED TO ASTHMA**	**COMMUNICABLE DISEASE EXAMPLES:** MEASLES, MUMPS, RUBELLA, POLIO, HEPATITIS, TETANUS, DIPTHERIA, MENINGITIS, PERTUSSIS, INFLUENZA, TUBERCULOSIS ACTIVE (ON MEDICATION) OR INACTIVE (NEGATIVE CHEST X-RAY)	**INJURY EXAMPLES:** CASTED FRACTURES, RECENT HEAD INJURIES, AND/OR LACERATIONS THAT HAVE STITCHES OR STAPLES – **MUST BE CLEARED BY DOCTOR**

If any items are circled in either column A or B please have the individual refrain from coming to camp.

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*ALL ABOVE INFORMATION WILL BE KEPT CONFIDENTIAL AND ONLY SHARED WITH JENNESS PARK STAFF OR YOUR CHURCH COUNSELOR, IN ORDER TO PROVIDE ADEQUATE HEALTH CARE FOR YOUR CHILD WHILE AT CAMP. THANK YOU.

SIGNATURE OF HEALTH SCREENER:____**Date** ______________

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Official Use:

Reviewed / / Supervisor ____________________