COLDSTREAM HEALTH SCREENING FORM
1 PER CHILD

CAMPER NAME _____

CAMP ATTENDING

- o DAY CAMP
- o ELEMENTARY
- o MIDDLE SCHOOL
- o HIGH SCHOOL

PARENT/GUARDIAN NAME _____

PARENT/GUARDIAN PHONE _____

HAS YOUR CHILD EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS IN THE LAST 5 DAYS?

Y/N FEVER
Y/N BODY ACHES
Y/N RUNNY NOSE/CONGESTION
Y/N COUGH
Y/N RASH
Y/N SKIN BLISTERS
Y/N SORE THROAT
Y/N CHANGE IN APPETITE
Y/N ITCHY OR RED/PINK EYES
Y/N CHANGE IN TASTE/SMELL
Y/N NAUSEA/VOMITING
OTHER NOTABLE SYMPTOMS: _____

DOES ANYONE IN YOUR HOUSEHOLD HAVE THE ABOVE SYMPTOMS?
YES/NO

HAS YOUR CHILD BEEN KNOWINGLY EXPOSED TO ANYONE WITH THE ABOVE SYMPTOMS?
YES/NO

HAS YOUR CHILD TESTED POSITIVE FOR ANY INFECTIOUS ILLNESS IN THE LAST TEN DAYS (FLU, STREP, PINKEYE, COVID-19, HAND FOOT MOUTH, ETC.)?
YES/NO

IF YOUR CHILD HAS ATTENDED ANOTHER CAMP OR EVENT IN THE LAST 5 DAYS, PLEASE PROVIDE THE NAME & LOCATION:
NAME OF CAMP/AFFILIATED CHURCH:_____

By signing, I indicate I have answered the above questions truthfully and my child is symptom-free on the day I drop them off for camp. I also give permission for Coldstream's medical staff to provide common, over-the-counter medication as needed for pain relief, respiratory symptoms, or for any other non-emergency medical reason.

PARENT/GUARDIAN SIGNATURE _____

STAFF ONLY: NURSE FOLLOW-UP NEEDED?
YES / NO

NURSE CLEARANCE:
YES / NO