



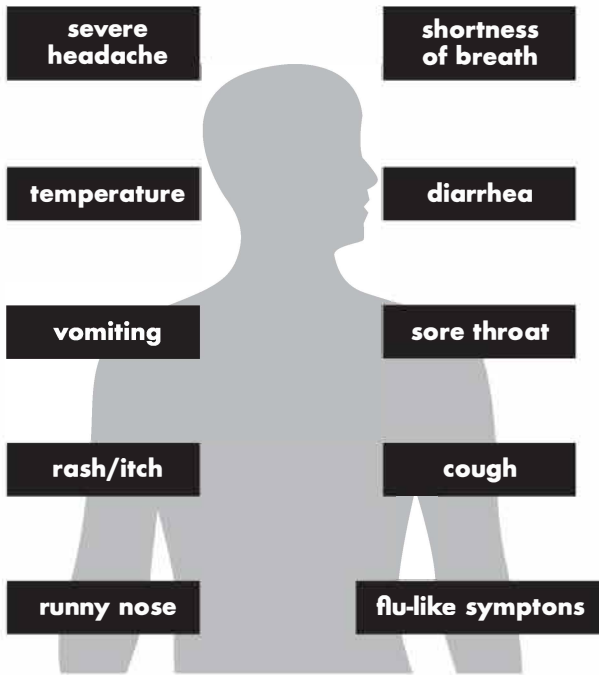
# PRE-ARRIVAL HEALTH INSPECTION FORM

(to be completed by a health care professional)

Camper Name: \_\_\_\_\_ Group Name: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Group Leader Name: \_\_\_\_\_

Emergency Contact #: \_\_\_\_\_ Group Leader Phone #: \_\_\_\_\_



Temperature: \_\_\_\_\_

\*\*\* IF over 100- Please stay home

Have you displayed any of the following symptoms in the past 72-hours:

- Severe headache
- Temperature
- Vomiting
- Rash/itch
- Runny nose
- Shortness of breath
- Diarrhea
- Sore throat
- Cough
- Flu-like symptoms

Circle one: Y / N

\*\*\* IF "Y" is circled- Please stay home

Please CIRCLE one of the following:

I can show proof of vaccination

I can show a negative test result within 72-hours

I have exercised hyper-vigilance in protecting myself from Covid-19 for the past 10-days

None of these apply to me

\*\*\* IF "None of these apply to me" is circled- Please stay home

Have you come in contact with a person who has tested positive for Covid-19 within the past 7-days?

Circle one: Y / N

\*\*\* IF "Y" is circled- Please stay home

> Completed by: \_\_\_\_\_

> Job Title/(certification held): \_\_\_\_\_

> Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\* QUESTIONS: Please contact us immediately at: 909-338-2705