Camp Parkwood

Pre-Screening Questionnaire

Camper: ____

Staff Name: _____________________________________

Group: ______________

Please answer the following truthfully and thoughtfully. If you answer "yes" to any question, then your responses will be reviewed by a designated medical leader to assess whether you may attend Camp Parkwood. The family or individual will be contacted after a decision is made by Camp Parkwood administrators.

Please check off Yes or NO.

Symptoms	YES	NO
Temperature above 100.0 F.		
Cough		
Sore throat		
Shortness of breath or difficulty breathing		
Loss of taste/smell		
Unexplained body aches		
Nasal congestion		
Diarrhea/Upset stomach/Vomiting		
Redness in the eyes +/- discharge		
Unexplained malaise/fatigue		
Headache		
Rash		

Have you or anyone in your household traveled outside of NEW YORK during the past 14 days?

YES or NO

Have you or anyone in your household tested positive for COVID-19 during the past 14 days?

YES or NO

Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19 during the last 14 days?

YES or NO

To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19 during the last 14 days?

YES or NO

Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19 during the last 14 days?

YES or NO

I confirm that the above information is accurate and current.

Parent/Staff Signature: ___________________________________

Date: ___________________