

New Castle Recreation & Parks
Health Screening Assessment – Summer Day Camp

Camper Name: _____ **Date:** _____

Camper Group: _____

In an effort to reduce illness at camp, we ask that you check on the health of your child daily. Please complete and return this form to us on the first day of camp.

Please initial each questions and indicate if your child has any symptoms. If symptoms are observed, please do not bring your child to camp. Please notify the camp director or camp health director of your child’s symptoms immediately.

Upon entrance to camp each day, a staff member will ask you the below questions and record a temperature check. If any answers of these questions are “yes” or a temperature is recorded, your child will not be allowed to enter the camp grounds.

If a child or camper begins to show symptoms after the start of the camp day, the attached flow charts will be followed in accordance to the NYS and Westchester Department of Health guidelines.

It is strongly recommended to have your child evaluated by a licensed healthcare provider prior to camp.

<p style="text-align: center;">Common COVID-19 Symptoms (Check All That Apply)</p> <ul style="list-style-type: none"><input type="checkbox"/> Cough<input type="checkbox"/> Shortness of breath or difficulty breathing<input type="checkbox"/> Fever<input type="checkbox"/> Chills<input type="checkbox"/> Muscle pain<input type="checkbox"/> Sore throat<input type="checkbox"/> New loss of taste or smell<input type="checkbox"/> Nausea<input type="checkbox"/> Vomiting<input type="checkbox"/> Diarrhea<input type="checkbox"/> Skin rash<input type="checkbox"/> Redness of eyes<input type="checkbox"/> Loss of appetite<input type="checkbox"/> Fatigue<input type="checkbox"/> Abdominal pain<input type="checkbox"/> Other _____ <p style="text-align: center;">Notify DOH within 24 hours if camper has temperature of 100.4°F and at least one additional symptom.</p>	<p style="text-align: center;">Please Initial</p> <ul style="list-style-type: none">• My child has not had any COVID-19 symptoms in the past 14 days. Initial _____ • My child has not tested positive for COVID-19 in the past 14 days. Initial _____ • My child has not had close or proximate contact with confirmed or suspected COVID-19 case in the past 14 days. Initial _____
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Parent Signature _____

For Office Use Only

Temperature Check Upon Arrival To Camp _____

Received By _____