HEALTH SCREENING **Church Name: _____**

To be completed by the church sponsor <u>on the day of departure</u> to camp. This will be reviewed with you by the Health Center Staff when you come through registration.

Please list for the Health Center the names of campers or adults who:

1. Are taking medications - prescription and/or over the counter
2. Have special health needs (i.e., asthma, diabetes, physical limitations, etc.)
3. Have allergies to foods, medicines, and insect stings
4. Have emergency medicines they keep with them (i.e., rescue inhalers, epi-pens)
5. Have had change in circumstances since their Medical Form was done, including
    a. any visit to a doctor or clinic in the last week
    b. any recent illness, injury, rash, or allergic reaction
    c. fever or other signs of illness or infection in the last 48 hours (i.e., nausea, vomiting, diarrhea, cold)
    d. contact with sick friends or family members in the last 48 hours
    e. any daily medication taken 2 weeks prior to camp or treatment for head lice within past month

Name	Screening comment

Print Leader Name _____ Phone # while at camp _____

Leader Signature _____ Date _____