

CAMP IDLEWILD OF FLORIDA

Greeter/Screening Questionnaire



DATE/SESSION: _____

CAMPER NAME: _____ TEMP _____

OF PASSENGERS IN VEHICLE: _____

NAME/TEMP: _____

NAME/TEMP: _____

NAME/TEMP: _____

NAME/TEMP: _____

Questions to be asked at Pre-screen station; if answered yes to any of the questions, please radio the Camp Director or Executive Director at this time to consult with family.

Question 1: Have you been diagnosed with or had symptoms suggestive of COVID19 in the last 14 days?

X-Yes X-No

Question 2: Have you cared for or come in contact with a person with confirmed or suspected COVID19 in the last 14 days?

X-Yes X-No

Symptoms: Has the camper or family/caregiver/guardian had any of the below symptoms in the last 14 days? Check any or all that apply:

- | | |
|---|--|
| <input type="radio"/> Fever | <input type="radio"/> New/Changed Headache |
| <input type="radio"/> Chills | <input type="radio"/> New/Changed Diarrhea |
| <input type="radio"/> New Shortness of Breath or Difficulty Breathing | <input type="radio"/> New or Changed Body Aches |
| <input type="radio"/> New Cough | <input type="radio"/> New Loss of Taste or Smell |

Actions Taken:

- ☐ Camper/Parent/Caregiver/Guardian continued to the next station
- ☐ Camper/Parent/Caregiver/Guardian consulted with the Camp Director or Executive Director and was authorized to continue to the next station.
- ☐ Camper/Parent/Caregiver/Guardian consulted with the Camp Director or Executive Director and due to safety concerns, were denied to continue with the check-in process.

Parent/Caregiver/Guardian Printed Name and Signature: _____

Greeter Name: _____