

Pre-Event Medical Screening Checklist

Arrival Temp _____

Must be filled out by everyone and brought to camp

This is a tool to assist leaders in identifying potentially communicable diseases in advance of event participation. The intent of this checklist is to review with each participant their current health status both before departure and upon arrival at the event.

Name: _____ Unit # _____ Council _____

Name: (Driver/Adult) _____

Names of all people in your vehicle:

Has any of the participant(s) in your vehicle had any of the following symptoms in the last 24 hours?

Yes No

- | | | |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Fever (100.4 F or greater) |
| <input type="checkbox"/> | <input type="checkbox"/> | Vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea |

If a participant has fever, vomiting, OR diarrhea—**he or she should stay home**

Has the participant had any contact with any persons with a confirmed case of COVID – 19

Yes No

Has the participant travelled internationally in the last 14 days. (or to one of the current restricted states)

Yes No

Has any of the participant(s) in your vehicle had any of the following symptoms in the last 24 hours?

Yes No

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Unexplained extreme fatigue or muscle aches |
| <input type="checkbox"/> | <input type="checkbox"/> | Rash |
| <input type="checkbox"/> | <input type="checkbox"/> | Cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Sore Throat |
| <input type="checkbox"/> | <input type="checkbox"/> | Open Sores |
| <input type="checkbox"/> | <input type="checkbox"/> | Flu Like Symptoms |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain |

If the participant has any two (or more) of these symptoms—**he or she should stay home**. If the participant has one of these symptoms, discuss any limitations and restrictions and consider having him or her stay home.

Participants who become ill should not return to the activity until they are cleared by a health-care provider.

Name of person completing this form: _____ Date: _____