



## Western Los Angeles County Council COVID-19 Pre-Camp Medical Screening Checklist

WLACC requires all campers to submit this COVID-19 Pre-Camp Medical Screening Checklist. This checklist will be turned in with other camp medical documents as required by the camps in our Council. All campers and other hired staff are required to check on their COVID potential symptoms and either not come to camp or report to the camp medical staff immediately upon feeling symptomatic. (See list below)

Yes  No Have you or has anyone in your household been in [close contact\\*](#) in the past 10 days with anyone known or suspected to have COVID-19 or is otherwise sick?

Yes  No Have you or has anyone in your household been in [close contact\\*](#) with anyone who has been tested for COVID-19 and is waiting for results?

Yes  No Have you or has anyone in your household been sick in the past 10 days, or have you or they been tested for any illness and are waiting for results?

Yes  No Has anyone in your household been exposed to an individual known or suspected to have COVID-19 in the past 10 days?

Yes  No Have you or has anyone you have been in close contact\* with traveled on a cruise ship or internationally or to an area with a known communicable disease outbreak in the past 10 days?

**\*According to the Centers for Disease Control and Prevention (CDC), "close contact" means:**

- You were within 6 feet of someone who has COVID-19 for a cumulative total of 15 minutes or more over a 24-hour period.
- You had direct physical contact with an infected person (hugged or kissed them).
- You shared eating or drinking utensils.
- An infected person sneezed, coughed, or otherwise got respiratory droplets on you.

***If the answer is YES to any one of the five questions above, the participant must stay home.***

***If all answers above are NO, proceed to the symptoms list below.***

### Symptoms of COVID-19

***If anyone in your household has any one of the following new or worsening signs or symptoms of possible COVID-19, the entire household must stay home.***

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Shortness of breath        | <input type="checkbox"/> Muscle or body aches | <input type="checkbox"/> Cough             | <input type="checkbox"/> Headache               |
| <input type="checkbox"/> Fever of 100.0° or greater | <input type="checkbox"/> Sore throat          | <input type="checkbox"/> Flu-like symptoms | <input type="checkbox"/> Loss of taste or smell |
| <input type="checkbox"/> Repeated chills            | <input type="checkbox"/> Diarrhea             | <input type="checkbox"/> Fatigue           | <input type="checkbox"/> Nausea or vomiting     |

***\*Potential Higher-Risk Individuals\****

Yes  No Are you in a higher-risk category as defined by the [CDC guidelines](#), people with medical conditions, and those with other individual circumstances?

***If the answer is "yes," we recommend that you stay home.***

***Should you choose to participate, you must have approval from your health care provider***

\_\_\_\_\_  
NAME:

\_\_\_\_\_  
DATE: