girl scouts of utah

Participant's Name: _____

Program Name: _____

Program Dates: _____

Directions

- This form is to be completed and brought to check-in day.
- Families are responsible for completing Side 1 only.
- Questions about this form can be directed to our Customer Care team at info@gsutah.org or 801-265-8472.
- More information regarding this Health Screen, along with required COVID-19 testing, vaccinations, and cancelling your registration can be found on our Summer Camp webpage (https://tinyurl.com/GSUCampCOVID).

Health Screen for COVID-19 Symptoms at Home

Section 1. Participants with one of the following symptoms during their at-home health screen cannot attend their camp session.	**Program Start Date**	**Day 1**	**Day 2**	**Day 3**	**Day 4**	**Day 5**	**Check-In Day**
	Mon. →	**Wed.**	**Thurs.**	**Fri.**	**Sat.**	**Sun.**	**Mon.**
	Wed. →	**Fri.**	**Sat.**	**Sun.**	**Mon.**	**Tues.**	**Wed.**
• Fever (temperature of 100.4F or higher) *Record temperature in box.*							
• New uncontrolled cough that causes difficulty breathing*		Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

Section 2. Participants with one of the following symptoms (that cannot be attributed to another cause) during their at-home health screen cannot attend their camp session.	**Program Start Date**	**Day 1**	**Day 2**	**Day 3**	**Day 4**	**Day 5**	**Check-In Day**
	Mon. →	**Wed.**	**Thurs.**	**Fri.**	**Sat.**	**Sun.**	**Mon.**
	Wed. →	**Fri.**	**Sat.**	**Sun.**	**Mon.**	**Tues.**	**Wed.**
• Sore throat		Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
• Diarrhea, vomiting, *or* stomachache		Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
• New onset of severe headache		Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
• Shortness of breath or difficulty breathing		Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
• New loss of taste or smell		Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

Section 3. Participants with 3 or more of the following symptoms *(that can not be attributed to another cause)* during their at-home health screen cannot attend their camp session.	**Program Start Date**	**Day 1**	**Day 2**	**Day 3**	**Day 4**	**Day 5**	**Check-In Day**
	Mon. →	**Wed.**	**Thurs.**	**Fri.**	**Sat.**	**Sun.**	**Mon.**
	Wed. →	**Fri.**	**Sat.**	**Sun.**	**Mon.**	**Tues.**	**Wed.**
• Nasal congestion or runny nose		Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
• Tiredness		Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
• Headache		Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
• Muscle or body aches		Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
• Poor appetite		Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

**If participant has a chronic allergic/asthmatic cough, mark "yes" if their cough is different from their usual cough.*

Testing Prior to Arrival at Camp

Section 1. Participants are **REQUIRED** to complete a PCR test unless they qualify for Section 2 or 3 below.

• PCR test completed on Thursday (Mon. start date) or Saturday (Wed. start date).	☐ Done ☐ N/A
• PCR test results uploaded in UltraCamp by 5pm Sunday (Mon. start date) or 5pm Tuesday (Wed. start date).	☐ Done ☐ N/A

Section 2. Participant has completed a COVID-19 vaccine series at least 14 days prior to arrival at camp.

• Vaccination card uploaded in UltraCamp by 5pm Sunday (Mon. start date) or 5pm Tuesday (Wed. start date).	☐ Done ☐ N/A

Section 3. Participant has been diagnosed with COVID-19 in the last 90 days.

• Email info@gsutah.org with: → Name of participant → Name of program → Date of diagnosis → Copy of COVID-19 test results (if test was administered)	☐ Done ☐ N/A

Important Reminders

Participants are to limit exposure to those outside of their household beginning the Thurs. morning (Mon. start date) or Sat. morning (Wed. start date) prior to arriving at camp.

If participants ***must*** interact with those outside their household remember they are to:

- Social distance (min. six feet).
- Wear their mask when unable to social distance.
- Practice increased hygiene measures (increase handwashing/hand sanitizer frequency, not sharing utensils or cups with others, etc.).

SIDE TWO: STAFF USE ONLY

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Participant's Name: _____ Program Name: _____

PCR Test Needed at Camp on Thurs: ____ YES ____NO *(see report)* Program Dates: _____

Health Screen for Camp Check-In Day (Day 1)

Section 1. Drive-Thru Check-In	**Comments**	**Staff Int.**
• Temperature. *If higher than 100.4F follow guidelines for retaking temperature.*		
• Outside of COVID-19, has the participant been exposed to any communicable diseases (chicken pox, whooping cough, hand/foot/mouth disease, lice, etc.) the last 20 days? *If yes, follow guidelines for this response.*		
• Any recent health concerns or changes since the participant's online health forms were completed? If yes, explain.		
• Any rashes, sores, or scabs we need to care for while participant is at camp? If yes, describe.		
Section 2. Post Drive-Thru Check-In	**Comments**	**Staff Int.**
• Head check performed	☐ Clear ☐ Health Supervisor Cleared (Initials:) ☐ Double Check Required with HS ☐ Treatment Required (Initials:)	

Staff Initials

Staff Int.	Staff Name

Health Screen for COVID-19 Symptoms at Camp

Section 1. One or more present → Visit health center.	**Day 2** / /21	**Day 3** / /21	**Day 4** / /21	**Day 5** / /21	**Day 6** / /21	**Day 7** / /21	**Day 8** / /21	**Day 9** / /21	**Day 10** / /21	**Day 11** / /21	**Day 12** / /21
• Fever (temperature of 100.4F or higher) *Record temperature in box.*											
• New uncontrolled cough that causes difficulty breathing*	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Section 2. One or more present (that cannot be attributed to another cause) → Visit health center.	**Day 2** / /21	**Day 3** / /21	**Day 4** / /21	**Day 5** / /21	**Day 6** / /21	**Day 7** / /21	**Day 8** / /21	**Day 9** / /21	**Day 10** / /21	**Day 11** / /21	**Day 12** / /21
• Sore throat	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
• Diarrhea, vomiting, *or* stomachache	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
• New onset of severe headache	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
• Shortness of breath or difficulty breathing	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
• New loss of taste or smell	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Section 3. Three or more present *(that can not be attributed to another cause)* → Visit health center.	**Day 2** / /21	**Day 3** / /21	**Day 4** / /21	**Day 5** / /21	**Day 6** / /21	**Day 7** / /21	**Day 8** / /21	**Day 9** / /21	**Day 10** / /21	**Day 11** / /21	**Day 12** / /21
• Nasal congestion or runny nose	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
• Tiredness	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
• Headache	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
• Muscle or body aches	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
• Poor appetite	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Initials of staff administering daily screening:											

**If participant has a chronic allergic/asthmatic cough, circle "Y" if their cough is different from their usual cough.*