Camp Sangamon Wellness Check

Camper Name: ______________________ **Cabin:** ________________

Age: __________________ **Allergies:** ________________

(circle if applicable: Food, Environmental, Med)

Meds: Yes No (please circle)

	Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		Day 7	
	yes	no	yes	no	yes	no	yes	no	yes	no	yes	no	yes	no
Cough														
Difficulty Breathing														
Fever (feeling feverish or temp above 100.4F)														
Chills														
Repeated shaking with chills														
Muscle or body aches														
Headache														
Sore Throat														
New loss of taste or smell														
Congestion or runny nose														
Nausea or vomiting diarrhea														
Exposure to Covid 19														
Contact with anyone with COVID-19 symptoms														
	Date:		Date:		Date:		Date:		Date:		Date:		Date:	
Initials														

Parent/Guardian Printed Name: ____________________________ **Camper Printed Name:** ____________________

Parent/Guardian Signature: ____________________________ **Camper Signature:** ______________________