

Camp/Activity Participant Pre-Screening Form

Date: _____

Name of Interviewer: _____

Youth/Adult Participant Name: _____

Name of Camp/Activity: _____

Unit Type: (Circle One) Pack Troop Crew Post Ship Other: _____

Unit #: _____

Please document the following for all youth and/or adults participating in camps or activities sponsored by the Central Florida Council, Boy Scouts of America.

<p>Influenza/Respiratory History: (Indicate "Yes" or "No")</p> <p>Do you have any of the following symptoms?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No -Fever equal to or greater than 37.8° C or 100° F or feverishness</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No -Nasal congestion</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No -Sore throat</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No -Cough</p>

If (2) TWO or more boxes are checked "yes" above, give the patient a regular mask to wear and instruct them to keep it on until told it is ok to take it off.

The medical officer or appropriate staff member will determine if any participant needs to be quarantined and parents of youth members called to pick them up from the camp/activity. The medical officer or appropriate staff member may also determine that an adult is unable to participate based on the above criteria.