CAMP OF THE RISING SON at FRENCH CAMP ACADEMY

We are grateful for your partnership with us to provide a safe and healthy enviornment for CRS.

Please print, fill out, and bring this form with you to 2021 staff training!

Full Name: _____

Date of Birth: _____Parent/Guardian (under 18): _____

Prior to your arrival at CRS please complete the steps listed on this requried form.

BE SURE TO BRING THIS FORM TO STAFF TRAINING.

Do not mail prior to arrival at CRS.

7-DAY RISK REDUCTION AND TEMPERATURE CHECK:

For the 7 days Immediately before your arrival at CRS, we ask that you commit to lowering your exposure risk to Covid-19. This meand limiting exposure to non-family members, wearing a face mask around non-family members, avoiding large crowds/gatherings, and limiting indoor gatherings. We also ask you to record your temperature. Please record this the same time each day. Those vaccinated please follow CDC safe activity recommendations.

Please check off each day completed and log temperature below:

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
RISK REDUCTION							
DAILY TEMPERATURE							

SYMPTOMS IN THE LAST WEEK WITHOUT OBVIOUS CAUSE

Check any that apply to you:

- ☐ FEVER
- ☐ COUGH
- ☐ SHORTNESS OF BREATH
- ☐ BODY ACHES
- ☐ FATIGUE
- ☐ NAUSEA/VOMITING
- ☐ DIARRHEA
- ☐ CHILLS
- ☐ RUNNY NOSE
- ☐ SORE THROAT
- ☐ LOSS OF TASTE/SMELL

If symptoms are present at time of arrival, you may arrive with a negative Covid-19 test taken within the last 48 hours or have camp perform the test. *Those arriving with a positive test may be sent home to quarantine.

☐ I HAVE BEEN SYMPTOM FREE FOR THE PAST 7 DAYS INITIAL HERE: ____

PRE-EXISTING ILLNESSES

Check any that apply to you:

- ☐ CARDIOVASCULAR DISEASE
- ☐ DIABETES
- ☐ RESPIRATORY DISEASE (including asthma)
- ☐ IMMUNOCOMPROMISE

Individuals with preexisting conditions such as cardiovascular disease, respiratory disease including asthma, diabetes, and immunocompromise are at increased risk of severe illness if Covid-19 is contracted. I understand that my pre-existing illness increases the implied risk of Covid-19.

☐ I UNDERSTAND THE IMPLIED RISK OF PRE-EXISTING ILLNESSSES INITIAL HERE: ____

CONTACT HISTORY

Check any that apply to you:

- ☐ I have been diagnosed with Covid-19. Date of positive test: _____
  - You will be eligible to arrive if you are 10 days post-test with no fever and improving symptoms for 24 hours.
- ☐ I have had a close contact with someone exposed to or infected with Covid-19 in the last 7 days.
- ☐ I have had a household member currently on a watchlist for Covid-19 exposure.

Please complete your quarantine prior to arriving at camp. For any recent exposure concerns, please email info@campoftherisingson.com prior to arrival.

☐ I VERIFY THAT I HAVE ANSWERED THIS QUESTION TRUTHFULLY INITIAL HERE: ____

The health and safety of our CRS campers, staff, and families is our #1 priority. In light of the Covid-19 pandemic, it is important that you understand CRS's efforts to manage your health and safety so that you can make an informed choice. We are taking all reasonable measures to prevent the spread of Covid-19 at CRS; however, we are unable to eliminate all risk. We have strengthened our standard cleaning procedures, while adding increased frequency measures for wiping down common touch points, dining areas and activity equipment. Additionally, we have taking measures to monitor and address symptomatic campers and staff by introducing this heath-screener, daily temperature checks, and protocols to isolate, confirm, respond, and remove any camper or staff with suspected Covid-19. Ultimately, the choice for you to attend CRS, or not, is a personal one, and you are in control.

☐ I CONSENT TO THE ABOVE DISLOSURE FOR SUMMER 2021 INITIAL HERE: ____

☐ I CONSENT TO RECEIVING A COVID-19 TEST IF SYMPTOMS ARRISE OR IF NECESSARY FOR SCREENING PURPOSES INITIAL HERE: ____

_____

SIGNATURE DATE

_____

PARENT/GUARDIAN SIGNATURE (under 18) DATE

FOR OFFICE USE ONLY

Initial Screening Date/Time: _____ Initials: _____ Temp: _____

A. Any signs/symptoms of illness or injury upon arrival?..... ☐ No ☐ Yes as noted below

B. History of exposure to communicable disease?..... ☐ No ☐ Yes as noted below

C. Additions or corrections to information on this health history?..... ☐ No ☐ Yes as noted below

D. Medication given to health-care staff?..... ☐ No ☐ Yes as noted below

E. Any signs/symptoms of head lice?..... ☐ No ☐ Yes as noted below

Provider notes: (date/time/initial all entries) _____

_____

_____