Daily Screening Checklist

Today's Date:		Activity Start Time:	
Participant Name:			
Activity/Group:			

	Do you have any of the symptom's below? Please circle your answer.		
1.	• Fever (greater than 38.0 C) and/or chills	Yes	No
	• Coughing	Yes	No
	• Sneezing	Yes	No
	• Soar throat and/or painful swallowing	Yes	No
	• Stuffy and/or runny nose	Yes	No
	• Fatigue related to illness	Yes	No
	• Loss of appetite	Yes	No
	• Shortness of breath	Yes	No
	• Loss of sense of smell	Yes	No
	• Headache	Yes	No
	• Muscle aches related to illness*	Yes	No
2.	Have you, or has anyone in your household travelled outside of Canada in the last 14 days?	Yes	No
3.	Have you, or has anyone in your household been in contact in the last 14 days with someone who is being investigated or who has a confirmed case of COVID 19?	Yes	No
4.	Are you currently being investigated as a suspect case of COVID 19?	Yes	No
5.	Have you tested positive for COVID 19 within the last 10 days?	Yes	No

Participant or
Parent/Guardian Name:_____Signature:_____

Emergency Contact #: _____

Staff Name: _____Signature:_____

*Note: Fatigue and muscle aches may be expected as athletes return to sport. All participants, parents/guardians of minors, and club personnel must determine the difference between this and symptoms of illness.