DAILY HEALTH SCREENING FORM

This questionnaire must be completed by each individual prior to participation in each on-ice or off-ice club/skating school activity.

The answer to all questions must be "NO" in order to participate in each activity.

1. Do you have a fever and/or chills? (Temperature of 37.8 degrees Celsius/100 degrees Fahrenheit)

   ___ YES ___ NO
2. Do you have ANY of the following symptoms:
   a. Cough or barking cough (croup) (Not related to asthma, post-infectious reactive airways, COPD, or other known causes or conditions you already have)
      ___ YES ___ NO
   b. Shortness of breath (Out of breath, unable to breathe deeply, not related to asthma or other known causes or conditions you already have)
      ___ YES ___ NO
   c. Sore throat / Difficulty Swallowing / Painful Swallowing (Not related to seasonal allergies, acid reflux, or other known causes or conditions you already have)
      ___ YES ___ NO
   d. Decrease or loss of smell or taste (Not related to seasonal allergies, neurological disorders, or other known causes or conditions you already have)
      ___ YES ___ NO
   e. Pink eye / Conjunctivitis (not related to reoccurring styes or other known causes or conditions you already have)
      ___ YES ___ NO
   f. Runny or stuffy/congested nose (Not related to seasonal allergies, being outside in cold weather, or other known causes or conditions you already have)
      ___ YES ___ NO
   g. Headache (Unusual, long-lasting, not related to tension-type headaches, chronic migraines, or other known causes or conditions you already have)
      ___ YES ___ NO
   h. Digestive issues like nausea/vomiting, diarrhea, stomach pain (Not related to irritable bowel syndrome, menstrual cramps, or other known causes or conditions you already have)
      ___ YES ___ NO
   i. Muscle aches (Unusual, long-lasting, not related to a sudden injury, fibromyalgia, or other known causes or conditions you already have)
      ___ YES ___ NO
   j. Extreme tiredness (Unusual, fatigue, lack of energy, not related to depression, insomnia, thyroid dysfunction, or other known causes or conditions you already have)
      ___ YES ___ NO
3. Has a doctor, health care provider, or public health unit told you that you should currently be isolating (staying at home)?
   ___ YES ___ NO
4. In the last 14 days, have you been identified as a "close contact" of someone who currently has COVID-19?
   ___ YES ___ NO
5. In the last 14 days, have you received a COVID Alert exposure notification on your cell phone? If you already went for a test and got a negative result, select "No."
   ___ YES ___ NO
6. In the last 14 days, have you or anyone you live with travelled outside of Canada? If you or anyone you live with are exempted from federal quarantine as per Group Exemptions, Quarantine Requirements under the Quarantine Act, select "No".
   ___ YES ___ NO
7. Is anyone you live with currently experiencing any new COVID-19 symptoms and/or waiting for test results after experiencing symptoms?
   ___ YES ___ NO

FIRST & LAST NAME: _____ DATE: _____

CONTACT EMAIL/PHONE: _____

(Non-Members, Non-club coaches, and Parents/Guardians/Siblings/Spectators Only)