

Daily Screening Checklist

Today's Date: _____

Activity Start Time: _____

Participant First and Last Name: _____

Activity Name: _____

			CIRCLE ONE	
1	Does the person attending the activity have any of the following symptoms:			
	* Fever (greater than 38C)		YES	NO
	* Cough		YES	NO
	* Shortness of Breath/Difficulty Breathing		YES	NO
	* Chills		YES	NO
	* Painful swallowing		YES	NO
	* Runny Nose/Nasal Congestion		YES	NO
	* Feeling unwell/Fatigued		YES	NO
	* Nausea/Vomiting/Diarrhea		YES	NO
	* Unexplained loss of appetite		YES	NO
	* Loss of sense of taste or smell		YES	NO
	* Muscle/Joint aches		YES	NO
	* Headache		YES	NO
	* Conjunctivitis		YES	NO
2	Have you, or anyone in your household, returned from travel outside of Canada in the last 14 days?		YES	NO
3	Have you or your children attending the program had close unprotected contact (face-to-face contact within two-meters) with someone who is ill with cough and/or fever?		YES	NO
4	Have you or anyone in your household been in close unprotected contact in the last 14 days with someone who is being investigated or confirmed to be a case of COVID-19?		YES	NO

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Staff Name: _____

Staff Signature: _____

If an individual answers **YES** to any of the questions, they **must not** be allowed to participate in the sport or activity.
Children and youth will need a parent to assist them to complete this screening tool.

If you have answered 'YES' to any of the above questions **do not** participate. Proceed home and use the AHS Online Assessment Tool to determine if testing is recommended.