COVID-19 Screening Form for Clients

Name of Client: ____ Date: _______________________________

1. Have you travelled outside of Canada in the last 14 days? **YES** or **NO**

2. Has someone you are in close contact with tested positive for COVID-19 in the last 14 days? **YES** or **NO**

3. Are you in close contact with a person who is sick with new respiratory symptoms or who recently travelled outside of Canada? **YES** or **NO**

4. Do you have a fever? (temperature ≥ 37.8° C) **YES** or **NO**

5. Do you have any of these symptoms?

   - ☐ Chills
   - ☐ New or worsening cough (dry or productive)
   - ☐ Barking cough (croup)
   - ☐ Shortness of breath / difficulty breathing
   - ☐ Sore throat
   - ☐ Difficulty swallowing
   - ☐ Loss of taste or smell
   - ☐ Pink eye (Conjunctivitis)
   - ☐ Headache that is unusual or long-lasting
   - ☐ Runny of stuffy nose (not related to seasonal allergies or other known causes of conditions)
   - ☐ Nausea / vomiting / diarrhea / abdominal pain
   - ☐ Muscle aches
   - ☐ Unexplained fatigue / malaise
   - ☐ Falling more than usual
   - ☐ Other ____________________________________

   If you have answered:

   - ☐ **NO** to all questions – **PASS**. You may enter the building and proceed as scheduled.
   - ☐ **YES** to any questions from #1 to #4 – **FAIL**. Go home immediately and self-isolate.
   - ☐ **YES** to **<u>#5 only</u>** – **FAIL**. Go to question #6.

6. Are these symptoms typical for you (i.e. history of allergies, migraines, other known medical condition that usually causes these symptoms)?

   - ☐ **YES** – Please self-isolate. Contact your doctor for a note confirming that symptoms are typical before returning to another training session.
   - ☐ **NO** – Go home immediately and self-isolate.

Client Signature: ____