



## Health Questionnaire and Declaration of Wellness

To prevent the spread of the COVID-19 in our community and reduce the risk of exposure within our facilities we require clients, instructors, support staff and visitors to complete this "Health Questionnaire and Declaration of Wellness". The health and safety of our clients and staff is paramount, therefore this form must be completed prior to entering the training facility.

<b>Date (yy/mm/dd):</b>	<b>Time:</b>
<b>Name (Last, First):</b>	

**Self-Declaration by Client/Instructor:** If you answer **YES** to any of these questions, **notify BFA staff immediately.**

1	Are you sick or exhibiting any of the following symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Fever <input type="checkbox"/> Dry cough <input type="checkbox"/> Body aches <input type="checkbox"/> Headache <input type="checkbox"/> Sore throat <input type="checkbox"/> Runny nose <input type="checkbox"/> Tiredness <input type="checkbox"/> Shortness of breath
2	Have you travelled outside of your home province or Canada in the last 14 days (Including the United States)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which province or country(s): Travel Dates (Departure): _____ Return date: _____
3	Has anyone in your household been quarantined (self or directed) or identified as a COVID-19 confirmed or suspected case? <input type="checkbox"/> Yes <input type="checkbox"/> No
4	To your knowledge, have you been exposed to anyone who has been quarantined (self or directed) or identified as a COVID-19 confirmed or suspected case? <input type="checkbox"/> Yes <input type="checkbox"/> No Please describe:

I \_\_\_\_\_ (Print Name) acknowledge and confirm that I am not experiencing any flu-like symptoms and agree to report to BFA staff if symptoms occur.

Signature:

Date: