



Daily Screening Checklist

This checklist may be updated as the situation progresses and from time to time.

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

1.	Do you have any of the symptoms below? Please circle your answer.		
	• Fever (greater than 38.0°C) and/or chills	Yes	No
	• Coughing	Yes	No
	• Sneezing	Yes	No
	• Sore 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
	• Nausea and/or Diarrhea	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 has been in contact with anyone being infected, suspected or diagnosed with COVID-19?	Yes	No
4.	Have you been tested awaiting results, and 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.