Daily Screening Checklist

Name: _____ Today's Date: _____

Group: _____ Training Time: _____

1	Do you have any of the symptoms below?		
	Fever (>38°C) and/or chills	Yes	No
	Coughing	Yes	No
	Sneezing	Yes	No
	Sore throat and/or painful swallowing	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
	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 is being investigated or who has a confirmed case of COVID-19?	Yes	No
4	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

Parent/Guardian Name: _____

Parent/Guardian Signature: _____