HEALTH SCREENING QUESTIONNAIRE

Skater Name: _____

This form **MUST** be handed in once for the Fall session and once for the Winter session. This form **MUST** be completed **DAILY** within 1-hour of your session start time. A verbal confirmation will be required prior to entry of the facility **DAILY**. Children and youth will need a parent to assist them to complete this screening tool.

Parent Signature: _____ Date: _____

1.	Does the attendee have any new onset (or worsening) of any of the following symptoms?	**Circle One**	
	Fever	YES	NO
	Cough	YES	NO
	Shortness of breath / Difficulty breathing	YES	NO
	Sore throat	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 (unrelated to training)	YES	NO
	Headache	YES	NO
	Conjunctivitis (commonly known as pink eye)	YES	NO
2.	Has the attendee travelled outside of Canada in the last 14 days?	YES	NO
3.	Has the attendee had close contact* with a confirmed case of COVID-19 in the last 14 days?	YES	NO
4.	Has the attendee had close contact with a symptomatic** close contact of a confirmed case of COVID-19 in the last 14 days?	YES	NO

* Face to face contact within 2 metres. A health care worker in an occupational setting wearing the recommended personal protective equipment is not considered to be close contact.
** ill/symptomatic means someone with COVID-19 symptoms on the list above.

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