Daily Screening Checklist

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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, nausea, or diarrhea	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
	• 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? (exempt if it is an essential worker who has no symptoms)	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

Participant or Parent/Guardian 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.