Drop-In Skating COVID-19 Screening Questionnaire

Date: ___________________________________

Name: ___________________________________

Phone Number: ___________________________________

1. Are you experiencing any of the following new or worsening symptoms or signs? Symptoms should not be chronic or related to other known causes or conditions.

   a. Fever or chills
   b. Difficulty or shortness of breath
   c. Cough
   d. Sore throat, trouble swallowing
   e. Runny nose / stuffy nose or nasal congestion
   f. Decrease or loss of smell or taste
   g. Nausea, vomiting, diarrhea, abdominal pain
   h. Not feeling week, extreme tiredness, sore muscles

   Answer: Yes or No

2. In the last 14 days, have you been in close contact with someone who is currently sick with a new cough, fever, has difficulty breathing or with a confirmed or probable case of COVID-19?

   Answer: Yes or No

3. Have you travelled outside Canada in the last 14 days or have been in contact with someone returning from outside of Canada? (This does not include essential workers who cross the Canada-US border regularly).

   Answer: Yes or No

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