 **Peace Memorial Multiplex**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This Form Must be Completed Daily Prior to Entering the Facility.**

\*\*If an individual answers **YES** to any of the following questions, they **MUST NOT** be allowed to participate in the sport or activity. Children and youth will need a parent to assist them to complete this screening tool.

|  |  |  |  |
| --- | --- | --- | --- |
| 1. | Does the person attending the activity have any of the following symptoms? | CIRCLE ONE | |
|  | * 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 | YES | NO |
|  | * Headache | YES | NO |
|  | * Conjunctivitis (Pink Eye) | YES | NO |
| 2. | Have you or anyone in your household, returned from travel outside of Canada in the last 14 days? | YES | NO |
| 3. | Have you or your children attending the program had close, unprotected contact (face-to-face contact within two-meters) with someone who is ill with cough and/ or fever? | YES | NO |
| 4. | Have you or anyone in your household been in close unprotected contact in the last 14 days with someone who is being investigated or confirmed to be a case of COVID-19? | YES | NO |

\*\*If you have answered **YES** to any of the abovequestions **DO NOT** participate. Proceed home and use the AHS online Assessment Tool to determine if testing is recommended.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_