



## Health Screening Questionnaire

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

This questionnaire must be completed by each individual prior to participating in any Club activity or game play situation. This questionnaire may be completed verbally.

The answer to all questions must be "No" to participate.

1. Do you have a fever? (Feeling hot to the touch, a temperature of 37.8C or higher)

Yes ☐

No ☐

2. Chills      Yes ☐      No ☐

3. Do you have any of the following symptoms?

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| • Cough that's new or worsening (continuous, more than usual)   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Barking cough, making a whistling noise when breathing  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Shortness of breath (out of breath, unable to breathe deeply)   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Runny nose<br>( <i>not related to seasonal allergies or other known causes or conditions</i> )                              | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Stuffy or congested nose<br>( <i>not related to seasonal allergies or other known causes or conditions</i> )                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Sore throat   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Difficulty swallowing   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Lost sense of taste or smell  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Pink eye  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Headache that is unusual or long lasting  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Digestive issues like nausea/vomiting, diarrhea, stomach pain<br>( <i>not related to other known causes or conditions</i> ) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| • Muscle aches that are unusual or long lasting   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

- Extreme tiredness that is unusual (fatigue, lack of energy) Yes ☐ No ☐
- Falling down often Yes ☐ No ☐
- For young children and infants: sluggishness or lack of appetite Yes ☐ No ☐

4. In the last 14 days, have you been in close physical contact with someone who tested positive for COVID-19?

Close physical contact means:

- being less than 2 metres away in the same room, workspace, or area
- living in the same home

Yes ☐ No ☐

5. In the last 14 days, have you been in close physical contact with a person who is currently sick with a new cough, fever, or difficulty breathing?

Close physical contact means:

- being less than 2 metres away in the same room, workspace, or area
- living in the same home

Yes ☐ No ☐

6. In the last 14 days, have you been in close physical contact with someone who returned from outside of Canada in the last 2 weeks, and is not an essential worker with exemption from mandatory quarantine?

Close physical contact means:

- being less than 2 metres away in the same room, workspace, or area
- living in the same home

Yes ☐ No ☐

7. Have you travelled outside of Canada in the last 14 days? (This does not include essential workers who cross the Canada-US border regularly).

Yes ☐ No ☐

If an individual answers “yes” to any of these questions, they are not permitted to participate in any club activities.

*Please note: This Health Screening questionnaire has been developed based on the current Ontario Ministry of Health Self-Assessment Tool.*