Future Champions Health Screening Questionaire – COVID-19

TODAY'S DATE: ______________________ GROUP START TIME: _______________

NAME (LAST, FIRST): __________________________ Parent / Guardian Initials ______

1.	Do you/your child have any new onset (or worsening) of any of the following symptoms:	**CIRCLE ONE**	
	• Fever TEMPERATURE: ______	**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	**YES**	**NO**
	• Headache	**YES**	**NO**
	• Conjunctivitis (commonly known as pink eye)	**YES**	**NO**
2.	Has the person attending the activity/facility travelled outside of Canada in the last 14 days?	**YES**	**NO**
3..	Have you/your child had close unprotected* contact (face-to-face contact within 2 meters/6 feet) with someone who has travelled outside of Canada in the last 14 days and who is ill**?	**YES**	**NO**
4.	Have you/your child attending the program or activity had close unprotected* contact (face-to-face contact within 2 meters/6 feet) in the last 14 days with someone who is ill**?	**YES**	**NO**
5.	Have you/your child 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**

Camp Safety Assistant Initials: ____

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