Team :_______________________________________

Participant's Name:____

Parent Signature:____

LJK COVID SCREENING FORM – V2.0 Date:________________________

1. Do you have a fever and/or chills? ☐Yes ☐No

2. Do you have any of the following symptoms? ☐Yes ☐No

   Cough ☐Yes ☐No

   Shortness of breath/difficulty breathing? ☐Yes ☐No

   Sore throat/difficulty swallowing? ☐Yes ☐No

   Runny nose, sneezing or nasal congestion? *(not related to other known causes such as seasonal allergies, etc.?)* ☐Yes ☐No

   Conjunctivitis or Pink Eye? ☐Yes ☐No

   Loss of taste or smell? ☐Yes ☐No

   Vomiting and/or diarrhea? ☐Yes ☐No

   Unexplained fatigue/malaise? ☐Yes ☐No

   Headache? ☐Yes ☐No

3. Have you travelled outside of Canada or had close contact with anyone that has travelled outside of Canada in the past 14 days? ☐Yes ☐No

4. Have you had close contact with anyone with respiratory illness or a confirmed or probable case of COVID-19? ☐Yes ☐No

If you have answered "Yes" to any of the above questions, please do not enter the facility for any reason and contact the LJK COVID-19 Response Team via email immediately (contact info is on our website) as well as your local Public Health Unit.

If you have tested positive for COVID-19 please follow the safe return to play guidelines available on the LJK website.

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