COVID-19 Daily Health Screening Questionnaire

Senior Fitness	Date:	
Individual's Name:		
Contact Number:		
	YES	NO
1. Do you feel unwell?		
2. Do you have any of these symptoms?		
Fever (chills, sweats) Fever is 38C or higher		
New or worsening of a previous cough		
Sore throat		
Headache		
Shortness of breath		
Muscle aches		
New or worsening sneezing		
New or worsening nasal congestion or runny nose		
Hoarse voice		
Diarrhea		
Unusual fatigue		
Loss of sense of smell or taste		
Red, purple or blueish lesions on the feet, toes or fingers without clear cause		
3. Have you taken Tylenol, Advil or any medication within the last 4 hours for the purpose of reducing a fever?		
4. In the past 14 days, have you travelled or lived with someone who has travelled outside of the Atlantic Bubble?		
5. In the last 14 days, have you had close contact (within 2 meters/6 ft) of someone confirmed to have COVID-19?		
6. Are you, or anyone in your household waiting for a result from a COVID-19 test?		

YES, to any of the above questions will result in the child/individual not being able to enter the activity today.

Participant Signature: _____

INSTRUCTOR Name: _____ Signature: _____