Kyle Shewfelt GYMNASTICS

HEALTH & WELLNESS
SCREENING CHECKLIST

PARTICIPANT'S NAME: _____

DATE: _____

1.	Does the attendee have any new onset (or worsening) of any of the following symptoms:	CIRCLE ONE	
	• Fever	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 attendee travelled outside of Canada in the last 14 days?	YES	NO
3.	Has the attendee had close contact* with a confirmed case of COVID-19 in the last 14 days?	YES	NO
4.	Has the attendee had close contact with a symptomatic** close contact of a confirmed case of COVID-19 in the last 14 days?	YES	NO

* Face-to-face contact within 2 metres. A health care worker in a occupational setting wearing the recommended personal protective equipment is not considered to be a close contact.
** 'Ill/symptomatic' means someone with COVID-19 symptoms on the list above.

PARENT/GUARDIAN NAME: _____

PARENT/GUARDIAN SIGNATURE: _____