CRMHA COVID-19 DAILY SCREENING CHECKLIST

Participant Name:_____

Participant's Spectator:_____

Today's Date: _____

Start time: _____

1	Do you have any of the symptoms below? Please check mark your answer		
	• Fever (greater than 38.0℃) and/or chills	☐ YES	☐ NO
	• Sore Throat and/or painful swallowing	☐ YES	☐ NO
	• Sneezing	☐ YES	☐ NO
	• Stuffy and/or runny nose	☐ YES	☐ NO
	• Fatigue related to illness	☐ YES	☐ NO
	• Loss of appetite	☐ YES	☐ NO
	• Shortness of Breath	☐ YES	☐ NO
	• Loss of sense of smell	☐ YES	☐ NO
	• Headache	☐ YES	☐ NO
	• Muscle Aches related to illness	☐ YES	☐ NO
2	Have you, or has anyone in your household travelled outside of Canada in the last 14 days?	☐ YES	☐ NO
3	Have you, or has anyone in your household been in contact in the last 14 days with someone who is being investigated or who has a confirmed case for COVID-19?	☐ YES	☐ NO
4	Are you currently being investigated as a suspect case of COVID-19?	☐ YES	☐ NO
5	Have you tested positive for COVID-19 in the past 10 days?	☐ YES	☐ NO

Participant or Parent/Guardian (under 18)

Name:_____

Signature:_____

Emergency Contact #:_____

Name/Relationship:_____