South County Predators Girls Hockey Association

COVID HEALTH SCREEING QUESTIONAIRE
THIS QUESTIONNAIRE IS TO BE COMPLETED BY EVERYONE PRIOR TO PARTICIPATION IN EACH ON -ICE OR OFF-ICE ACTIVITY.

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Participant Name Time & Location of Activity

Are you currently experiencing any of these issues? Call 911 if you are.

1. Severe difficulty breathing (struggling for each breath, can only speak in single words)
2. Severe chest pain (constant tightness or crushing sensation)
3. Feeling confused or unsure of where you are
4. Losing consciousness

If you are in any of the following at risk groups, we ask that you speak with your physician prior to participating.

1. 70 years old or older
2. Getting treatment that compromises (weakens) your immune system (ex: chemotherapy, medication for transplants, corticosteroids, TNF inhibitors)
3. Having a condition that compromises (weakens) your immune system (ex: diabetes, emphysema, asthma, heart condition)
4. Regularly going to a hospital or health care setting for a treatment (ex: dialysis, surgery, cancer treatment)

For the following questions, close physical contact means living in the same home or being less than 2m away in the same room, workspace, or area for over 15 minutes. **The answer to all questions must be "No" to participate in each activity.**

1.	In the last 14 days, have you tested positive for COVID-19 or been in close physical contact with someone who tested positive for COVID-19?	YES	NO
2.	In the last 14 days, have you been in close physical contact with a person who is currently sick with a new cough, fever, or difficulty breathing?	YES	NO
3.	In the past 14 days, have you or anyone you have had close contact with travelled outside of Canada (not including essential workers travelling for work only)?	YES	NO
4.	Are you experiencing any of the following symptoms?		
a)	Do you have a fever or chills	YES	NO
b)	Cough that's new or worsening, barking cough, making a whistling noise when breathing	YES	NO
c)	Shortness of breath (out of breath, unable to breathe deeply)	YES	NO
d)	Sore throat or difficulty swallowing	YES	NO
e)	Runny nose, sneezing or nasal congestion (not related to seasonal allergies or other known causes or conditions)	YES	NO
f)	Lost sense of taste or smell	YES	NO
g)	Pink eye (conjunctivitis)	YES	NO
h)	Headache that’s unusual or long lasting	YES	NO
i)	Digestive issues (nausea/vomiting, diarrhea, stomach pain)	YES	NO
j)	Muscle Aches, Extreme tiredness that is unusual, falling down often	YES	NO
k)	For young children and infants: sluggishness or lack of appetite	YES	NO

Please note: This Health Screening questionnaire has been developed based on the Ontario Ministry of Health