DAILY SCREENING CHECKLIST
NEXT LEVEL TRAINING SUMMER 2020 HOCKEY CAMPS

Today's Date:_________________________________
Participant Name and Start time:____________________

1	Do you have any of the symptoms below? Please check mark your answer		
	•Fever (greater than 38.0°C) and/or chills	☐Yes	☐No
	•Coughing	☐Yes	☐No
	•Sore Throat and/or painful swallowing		
	•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:_______________________________________