SCREENING QUESTIONNAIRE

Please complete the following questions before attending each in-person lesson or event.
(Each attending family member must complete questionnaire.)

NAME: _____

DATE: _____

DO YOU HAVE ANY OF THE FOLLOWING:

	Yes	No		Yes	No
 Fever	☐	☐	 Runny nose*	☐	☐
 Cough	☐	☐	 Loss of taste or smell	☐	☐
 Difficulty breathing	☐	☐	 Not feeling well	☐	☐
 Sore throat, trouble swallowing	☐	☐	 Nausea, vomiting, diarrhea	☐	☐

	Yes	No
Have you been in close contact with someone who is sick or has confirmed COVID-19 in the past 14 days?	☐	☐
Have you returned from travel outside Canada in the past 14 days?	☐	☐

If you answered YES to any of these questions, go home and self-isolate right away.

** Allergies excepted*