Daily Screening Questions for All Aquatic Facility Visitors

NAME:

Phone #:

DATE:

Home Address:

1. Do you have any of the following symptoms: fever, new or existing cough and difficulty breathing? fever and/or new onset dry cough, tiredness, difficulty breathing, conjunctivitis, diarrhea, muscle pain, headache, sore throat, loss of taste or smell, skin rash, or discolouration of the fingers and toes?

2. Have you traveled outside of Canada within the last 14 days?

3. Have you had close contact with a confirmed or probable COVID-19 case?

4. Have you had close contact with a person with acute respiratory illness who has been outside Canada in the last 14 days?

5. Have you been advised by a medical professional to self-isolate?

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