Date:

Participant Name:

Questions:

Are you or any of your family members experiencing any of these symptoms? Fever, chills, new onset of cough, shortness of breath, sore throat, difficulty swallowing, runny nose, stuffy or congested nose, lost sense of taste or smell, pink eye, headache, digestive issues (nausea/vomiting, diarrhea), extreme tiredness, for young children and infants: sluggishness or lack of appetite?

Yes **No**

Have you or any of your family members been exposed to someone with COVID-19 or someone who has developed new respiratory symptoms?

Yes **No**

Have you travelled outside of Canada in the last 14 days?

Yes **No**

Parent/Guardian Name:

Parent/Guardian Signature:

Parent/Guardian Phone Number:

Emergency Contact Name:

Emergency Contact Phone Number:

If you answered YES to any of the above questions please DO NOT attend