Beaver Valley Figure Skating Club COVID-19 Health Screening Questionnaire

This must be completed by each individual prior to participation in each on-ice or off-ice BVFSC activity.

If any answer to the below questions is "Yes" you not permitted into the facility.

COVID-19 Screening Questions

Name of Participant : ________________________________

Name of Parent/Guardian : ___________________________________

Date: ____

Program: ____

1. Have you travel outside of Canada in the past 14 days?

2. Have you tested positive for COVID-19 or had close contact with a confirmed case of COVID-19?

3. Do you have any of the following symptoms:

- Fever
- New onset of cough
- Worsening chronic cough
- Shortness of breath
- Difficulty breathing
- Sore throat (not related to allergies or other known causes)
- Difficulty swallowing
- Decrease or loss of sense of taste or smell
- Chills
- Headaches
- Unexplained fatigue that is unusual
- Muscle aches that are unusual or long lasting
- Nausea/vomiting, diarrhea, abdominal pain (not related to allergies or other known causes)
- Pink eye
- Runny nose/nasal congestion (not related to allergies or other known causes)

☐ No, to **ALL** of the above questions

☐ Yes, to any of the above questions