Peaks Gymnastics Daily Screening Checklist

Must be completed daily by anyone entering the facility.

Today's Date:	
Participant Name:	

1.	Do you have any of the symptoms below? Please circle your answer.		
	• Fever (greater than 38ºC) and/or chills	Yes	No
	• Coughing	Yes	No
	• Sneezing (not related to allergies)	Yes	No
	• Stuffy and/or runny nose (not related to allergies)	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
	• Nausea or diarrhea	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 show has a confirmed case of 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 last 10 days?	Yes	No
6.	Is someone in your household currently feeling unwell?	Yes	No

Participant or Parent/Guardian name (if under 19):	
Signature:	

*Note: fatigue and muscle aches may be expected as athletes return to sport. All participants, parents/guardians or minors, and club personnel must determine the difference between this and symptoms of illness.