Stratford Flames COVID-19 Screening Form

Date and Time (yyyy/mm/dd): ____

Name: __________________________________Phone Number _______________________

SECTION 1: SYMPTOM SCREENING

1. Do you have any of the following primary symptoms:

• Fever - New or worsening cough - Shortness of breath
• Sore throat - Vomiting - Diarrhea - Decrease/loss of smell / taste **Y / N**

2. Do you have any of the following secondary symptoms:

• Runny nose or sneezing Nasal congestion (without other known cause)
• Hoarse voice - Difficulty swallowing - Chills - Headaches
Unexplainable fatigue - Unexplainable, generalized muscle aches
• Nausea or abdominal pain - Pink eye (conjunctivitis) **Y / N**

SECTION 2: TRAVEL HISTORY / CONTACT HISTORY

3. Have you travelled outside Canada within the last 14 days? **Y / N**

4. Have you had close, unprotected contact with a confirmed or probable case of COVID-19? Y / N

5. Have you had close, unprotected contact with a person with acute respiratory illness who has been outside Canada in the 14 days? **Y / N**

SECTION 3: IMMEDIATELY PROCEED WITH THE FOLLOWING ACTIONS

a. If pass symptoms and travel/contact history, they can continue
b. If pass symptoms and fail travel/contact history they must put on a mask
c. If fail symptoms and pass travel/contact history, put on a mask and go home
d. If fail symptoms and fail travel/contact history, put on a mask, go home

Signature (Or Guardian) ____