CALGARY Gymnastics Centre

HEALTH & WELLNESS SCREENING CHECKLIST

**Will be updated to reflect any Government of Alberta and Alberta Health Services changes to questions and requirements*

Name *(First & Last)*: _____ **Date:** _____

Emergency Phone Number: _____ **Class/Training Start Time:** _____

Program *(circle one)*: **GFA** **WAG** **MAG** **T&T** **Office** **Caretaker** **Other**

If an individual answers **YES** to any of the questions, they **must not** be allowed to participate in the sport or activity. Children and youth will need a parent to assist them to complete this screening tool.

1	Does the person attending the activity, have any of the following symptoms	Circle One	
	• Fever	YES	NO
	• Cough	YES	NO
	• Shortness of Breath/Difficulty Breathing	YES	NO
	• Sore Throat	YES	NO
	• Chills	YES	NO
	• Painful swallowing	YES	NO
	• Runny nose/ Nasal congestion	YES	NO
	• Feeling unwell/ fatigued	YES	NO
	• Nausea/ Vomiting/ Diarrhea	YES	NO
	• Unexplained loss of appetite	YES	NO
	• Loss of sense of taste or smell	YES	NO
	• Muscle/ Joint aches	YES	NO
	• Headache	YES	NO
	• Conjunctivitis	YES	NO
2	Have you,or anyone in your household, returned from travel outside of Canada in the last 14 days?	YES	NO
3	Have you or your children attending the program had close unprotected contact (face-to-face contact within two-meters) with someone who is ill with cough and/or fever?	YES	NO
4	Have you or anyone in your household been in close unprotected contact in the last 14 days with someone who is being investigated or confirmed to be a case of COVID- 19?	YES	NO

Staff Name:_____ **Staff Signature:**_____

If you have answered "**YES**" to any of the above questions **do not** participate. Proceed home and use the AHS Online Assessment Tool to determine if testing is recommended.