COVID-19 Required Screening Questions

This questionnaire must be completed by each individual prior to participation in each on-ice or off-ice activity. This questionnaire may be completed verbally. Your Trainer will ask you to confirm that you have completed the questionnaire and answered no to all questions before you will be permitted to participate in the activity. If you have answered yes to any of the questions, please inform your Coach or trainer prior to coming to the arena/facility.

1. Are you currently experiencing one or more of the symptoms below that are new or worsening? Symptoms should not be chronic or related to other known causes or conditions.

For individuals who are 18 years of age and older:

Do you have one or more of the following symptoms?	☐ **Yes** ☐ **No**
Fever and/or chills	Temperature of 37.8 degrees Celsius/100 degrees Fahrenheit or higher
Cough or barking cough (croup)	Not related to asthma, post-infectious reactive airways, COPD, or other known causes or conditions you already have
Shortness of breath	Not related to asthma or other known causes or conditions you already have
Sore throat	Not related to seasonal allergies, acid reflux, or other known causes or conditions you already have
Difficulty swallowing	Painful swallowing (not related to other known causes or conditions you already have)
Decrease or loss of smell or taste	Not related to seasonal allergies, neurological disorders, or other known causes or conditions you already have
Pink eye	Conjunctivitis (not related to reoccurring styes or other known causes or conditions you already have)
Runny or stuffy/congested nose	Not related to seasonal allergies, being outside in cold weather, or other known causes or conditions you already have
Headache	Unusual, long-lasting (not related to tension-type headaches, chronic migraines, or other known causes or conditions you already have) If you received a COVID-19 vaccination in the last 48 hours and are experiencing a mild headache that only began after vaccination, select "No."
Digestive issues like nausea/vomiting, diarrhea, stomach pain	Not related to irritable bowel syndrome, menstrual cramps, or other known causes or conditions you already have
Muscle aches/joint pain	Unusual, long-lasting (not related to a sudden injury, fibromyalgia, or other known causes or conditions you already have) If you received a COVID-19 vaccination in the last 48 hours and are experiencing mild muscle aches/joint pain that only began after vaccination, select "No."
Fatigue	Unusual tiredness, lack of energy (not related to depression, insomnia, thyroid dysfunction, or other known causes or conditions you already have)

	If you received a COVID-19 vaccination in the last 48 hours and are experiencing mild fatigue that only began after vaccination, select “No.”
Falling down often	For older people

For Individuals under 18 years of age

Do you have one or more of the following symptoms?	☐ Yes ☐ No
Fever and/or chills	Temperature of 37.8 degrees Celsius/100 degrees Fahrenheit or higher
Cough or barking cough (croup)	Continuous, more than usual, making a whistling noise when breathing (not related to asthma, post-infectious reactive airways, or other known causes or conditions you already have)
Shortness of breath	Out of breath, unable to breathe deeply (not related to asthma or other known causes or conditions you already have)
Decrease or loss of smell or taste	Not related to seasonal allergies, neurological disorders, or other known causes or conditions you already have
Sore throat or difficulty swallowing	Painful swallowing (not related to seasonal allergies, acid reflux, or other known causes or conditions you already have)
Runny or stuffy/congested nose	Not related to seasonal allergies, being outside in cold weather, or other known causes or conditions you already have
Headache	Unusual, long-lasting (not related to tension-type headaches, chronic migraines, or other known causes or conditions you already have) *If you received a COVID-19 vaccination in the last 48 hours and are experiencing a mild headache that only began after vaccination, select “No.”*
Nausea, vomiting and/or diarrhea	Not related to irritable bowel syndrome, anxiety, menstrual cramps, or other known causes or conditions you already have
Extreme tiredness or muscle aches	Unusual, fatigue, lack of energy (not related to depression, insomnia, thyroid dysfunction, sudden injury, or other known causes or conditions you already have) *If you received a COVID-19 vaccination in the last 48 hours and are experiencing mild muscle aches that only began after vaccination, select “No.”* *If you received a COVID-19 vaccination in the last 48 hours and are experiencing mild fatigue that only began after vaccination, select “No.”*

To be answered by everyone

2. Has a doctor, health care provider, or public health unit told you that you should currently be isolating (staying at home)?

This can be because of an outbreak or contact tracing.

☐ Yes ☐ No

3. In the last 10 days, have you tested positive on a rapid antigen test or a home- based self-testing kit?

If you have since tested negative on a lab-based PCR test, select "No."

☐ Yes ☐ No

4. In the last 14 days, have you been identified as a "close contact" of someone who currently has COVID-19?

If public health has advised you that you do not need to self-isolate (e.g., you are fully vaccinated‡ or another reason), select "No."

☐ Yes ☐ No

5. In the last 14 days, have you received a COVID Alert exposure notification on your cell phone?

If you are fully vaccinated‡ or have already gone for a test and got a negative result, select "No."

☐ Yes ☐ No

6. In the last 14 days, have you travelled outside of Canada AND been advised to quarantine per the federal quarantine requirements?

☐ Yes ☐ No

7. In the last 14 days, has someone in your household (someone you live with):

- **travelled outside of Canada AND been advised to quarantine per the federal quarantine requirements; OR**
- **been identified as a "close contact" of someone who currently has COVID-19 AND advised by a doctor, healthcare provider or public health unit to self- isolate?**

If you are fully vaccinated ‡, select "No."

☐ Yes ☐ No

8. **Is anyone you live with currently experiencing any new COVID-19 symptoms and/or waiting for test results after experiencing symptoms?**

If you are fully vaccinated‡, select "No."

☐ Yes ☐ No

If the individual experiencing symptoms received a COVID-19 vaccination in the last 48 hours and is experiencing mild headache, fatigue, muscle aches, and/or joint pain that only began after vaccination, select "No."

‡ Fully vaccinated is defined as an individual ≥14 days after receiving their second dose of a two-dose COVID-19 vaccine series or their first dose of a one-dose COVID-19 vaccine series.

Results of Screening Questions:

If an individual has answered "Yes" to any of these questions, they are not permitted to participate in any on-ice or off-ice activities. Please call your trainer immediately and let them now that you have responded positively to questions in the Ravens Health Screening Questionnaire. If you don't have contact information for your trainer please e-mail - your name; age group; date and time of activity to c19responseteam@waterlooravens.com

Please note: This Health Screening questionnaire has been developed based on the Ontario Ministry of Health Self-Assessment Tool (July 16, 2021).