University Tennis Centre COVID-19 Screening Form

Date: _______________________________ Time: _________________________________

Participant's Name: ___________________________Phone Number: __________________________

Parent Signature (if participant is under age 18):____

1. Do you have a fever and/or chills Yes ____ No ____

2. Do you have any of the following symptoms?

   Cough? Yes ____ No ____

   Shortness of breath/difficulty breathing? Yes ____ No ____

   Sore throat/difficulty swallowing? Yes ____ No ____

   Runny nose, sneezing or nasal congestion? Yes ____ No ____
   (not related to other known causes such as seasonal allergies, etc?)

   Conjunctivitis or pink eye? Yes ____ No ____

   Loss of taste or smell? Yes ____ No ____

   Vomiting and/or diarrhea? Yes ____ No ____

   Unexplained fatigue/malaise? Yes ____ No ____

   Headache? Yes ____ No ____

3. Have you travelled outside of Canada or had close contact with anyone that has travelled outside of Canada in the past 14 days? Yes ____ No ____

4. Have you had close contact with anyone with respiratory illness or a confirmed or probable case of COVID-19? Yes ____ No ____

If you have answered "Yes" to any of the above questions, please do not enter the facility for any reason.

Please note: This Health Screening Questionnaire has been developed based on the current Ontario Ministry of Health Self-Assessment Tool.