COVID-19 CHECKLIST FOR STAFF/COACHES/PARTICIPANTS

All participants must complete this questionnaire prior to each training session.
If a participant answers "YES" to any question, they are not permitted to participate in in-person soccer activities for a minimum of 14 days.

DATE: NAME:

AGE GROUP:
ADDRESS:

EMAIL:

PHONE:

SESSION TIME

DO YOU EXPERIENCE ANY OF THE FOLLOWING SYMPTOMS?

a) FEVER (38.0 Celsius or higher)
b) COUGH
c) SHORTNESS OF BREATH/ DIFFICULTY BREATHING
d) SORE THROAT
e) RUNNY NOSE

HAS ANYONE IN YOUR HOUSEHOLD EXPERIENCED ANY OF THE THESE SYMPTOMS IN THE PAST 14 DAYS? HAVE YOU OR ANYONE IN YOUR HOUSEHOLD TRAVELLED OUTSIDE OF CANADA IN THE PAST 14 DAYS? HAVE YOU OR ANYONE IN YOUR HOUSEHOLD BEEN IN CONTACT IN THE PAST 14 DAYS WITH SOMEONE WHO IS BEING INVESTIGATED AS A SUSPECTED CASE OF COVID-19?
ARE YOU CURRENTLY BEING INVESTIGATED AS A SUSPECTED CASE OF COVID-19?
HAVE YOU TESTED POSITIVE FOR COVID-19 IN THE PAST 10 DAYS?

I HEREBY CONFIRM THAT NONE OF THE ABOVE APPLIES TO MY SON/DAUGHTER:

RETURN TO PLAY COVID - 19 CHECKLIST

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