

Daily Screening Checklist

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

Today's Date: _____ **Activity Start Time:** _____

Participant First and Last Name: _____

Activity/Group Name: _____

1.	Do you have any of the below symptoms:	CIRCLE ONE	
		YES	NO
	• Fever (greater than 38.0C)	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 travelled 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 household been in close <u>unprotected</u> 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 the participant has 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.