TOWN OF CLARESHOLM

Claresholm Aquatic Centre

COVID-19 Screening Checklist

TODAY'S DATE _____

NAME (PLEASE PRINT) _____

CONTACT NUMBER _____

If you can answer YES to any of the below listed questions you must not enter our Facility:

1.	Do you have any of the following symptoms:	Yes	No
	Fever		
	Cough		
	Shortness of Breath / Difficulty Breathing		
	Sore throat		
	Chills		
	Painful Swallowing		
	Runny Nose / Nasal Congestion		
	Feeling unwell / Fatigued		
	Nausea/ Vomiting/ Diarrhea		
	Unexplained loss of appetite		
	Loss of sense of taste or smell		
	Muscle/ Joint aches		
	Headache		
	Conjunctivitis		
2.	Have you, or anyone in your household travelled outside of Canada in the last 14 days?		
3.	Have you or your children attending this program had close unprotected* contact (face-to-face contact within 2m/ 6ft) with someone who is ill with a cough and/or fever?		
4.	Have you or anyone in your household been n close unprotected contact in the last 14 days with someone who is being investigated or confirmed to be a case of COVID-19?		

SIGNATURE _____

Temp & Date	Temp & Date	Temp & Date	Temp & Date	Temp & Date	Temp & Date	Temp & Date

OFFICE USE ONLY

TIME OF PROGRAM _____ EXITED FACILITY TIME _____

PROGRAM TYPE _____ STAFF INTIAL _____