

GLHA Health Screening Questionnaire

DATE: _____



Team : _____ Participant's Name: _____ Parent Signature: _____

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. Are you currently experiencing any of these issues? Call 911 if you are.

- Severe difficulty breathing (struggling for each breath, can only speak in single words)
- Severe chest pain (constant tightness or crushing sensation)
- Feeling confused or unsure of where you are
- Losing consciousness

If you are in any of the following at risk groups, we ask that you speak with your physician prior to participating.

- Getting treatment that compromises (weakens) your immune system (for example, chemotherapy, medication for transplants, corticosteroids, TNF inhibitors)
- Having a condition that compromises (weakens) your immune system (for example, lupus, rheumatoid arthritis, immunodeficiency disorder)
- Having a chronic (long-lasting) health condition (for example, diabetes, emphysema, asthma, heart condition, COPD)
- Regularly going to a hospital or health care setting for a treatment (for example, dialysis, surgery, cancer treatment)

The answer to all questions must be "No" in order to participate in any and all activity.

1. Are you currently experiencing any of these symptoms?

- | | | | | | |
|--|--------------------------|-----|--------------------------|----|--------------------------|
| a. Do you have a fever? (Feeling hot to the touch, a temperature of 37.8C or higher)..... | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| b. Chills..... | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| c. Cough that's new or worsening (continuous, more than usual)..... | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| d. Barking cough, making a whistling noise when breathing (croup)..... | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| e. Shortness of breath (out of breath, unable to breathe deeply)..... | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| f. Sore throat..... | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| g. Difficulty swallowing..... | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| h. Runny nose, sneezing or nasal congestion (not related to seasonal allergies or other known causes or conditions)..... | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| i. Lost sense of taste or smell..... | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| j. Pink eye (conjunctivitis)..... | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| k. Headache that's unusual or long lasting..... | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| l. Digestive issues (nausea/vomiting, diarrhea, stomach pain)..... | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| m. Muscle aches..... | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| n. Extreme tiredness that is unusual (fatigue, lack of energy)..... | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| o. Falling down often..... | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| p. For young children and infants: sluggishness or lack of appetite..... | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

For the remaining questions, close physical contact means:

- Being less than 2 metres away in the same room, workspace, or area for over 15 minutes **AND/OR** Living in the same home

- | | | | | | |
|---|--------------------------|-----|--------------------------|----|--------------------------|
| 2. In the last 14 days, have you been in close physical contact with someone who tested positive for COVID-19? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 3. In the last 14 days, have you been in close physical contact with a person who either: Is currently sick with a new cough, fever, or difficulty breathing; OR Returned from outside of Canada in the last 2 weeks? (This does not include essential workers who cross the Canada-US border regularly.) | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 4. Have you travelled outside of Canada in the last 14 days? (This does not include essential workers who cross the Canada-US border regularly.) | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

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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 note: This Health Screening questionnaire has been developed based on the Ontario Ministry of Health Self-Assessment Tool (September 14, 2020).