COVID-19 SCREENING CHECKLIST

Musician name ______________________________ Phone number _________________

ARE YOU EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?

- ☐ Fever (feeling hot to the touch, a temperature of 37.8 degrees Celsius or higher)
- ☐ Chills
- ☐ Cough that is new or worsening
- ☐ Shortness of Breath
- ☐ Sore throat
- ☐ Difficulty Swallowing
- ☐ Runny/stuffy of congested nose
- ☐ Loss of sense of taste or smell
- ☐ Pink eye
- ☐ Headache – unusual or long lasting
- ☐ Digestive issues unrelated to known causes or conditions – nausea/vomiting, diarrhea, stomach pain
- ☐ Extreme tiredness
- ☐ Muscle aches – unusual or long lasting

IN THE PAST 14 DAYS, HAVE YOU:

- Been in close contact with someone who tested positive for COVID-19?
  ◯ Yes ◯ No
- Travelled outside of Canada?
  ◯ Yes ◯ No
- Been in close physical contact with a person who has returned from outside of Canada in the last 2 weeks?
  ◯ Yes ◯ No

**** If you have answered YES to **any** of the items above, you will **not** be permitted to enter our facility, if you are able to answer **NO** to **all** of the above, please sign below.

Signature (Please type in your full name) ______________________________

Date of Rehearsal ___________________________

PLEASE SANITIZE AT OUR STATION AND WEAR YOUR MASK TO HELP REDUCE THE SPREAD OF COVID-19. THANK YOU.