Ontario Amateur Wrestling Association
COIVD-19 Screening Questionnaire Checklist

SESSION DATE: _____
TIME: _____

All participants MUST be screened before beginning training.

Screener Name: _____

PARTICIPANT'S NAME Þ																				
Do you have any of the following new or worsening signs of symptoms?	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
New or unexplained cough																				
Unexplained fatigue or malaise																				
Shortness of Breath																				
New smell or taste disorder																				
Severe chest pain																				
Feeling confused																				
Sore throat or difficulty swallowing																				
Nausea, vomiting, diarrhea, abdominal pain																				
Headache																				
Chills																				
Fever																				
Have you Travelled outside of Canada or come in contact with someone who has travelled outside of Canada in the past 14																				
Have you come in recent contact with anyone who has had a probable or confirmed case of COVID-19?																				

IMPORTANT: IF THE PERSON BEING SCREENED ANSWERS 'YES' TO ANY OF THE ABOVE QUESTIONS, THEY ARE NOT TO ENTER THE TRAINING FACILITY AND SHOULD BE REFERRED TO LOCAL HEALTH AUTHORITIES

This form is to be retained by the Club Administrator

Screener: Initial Here to confirm you have viewed the individual's confirmation of COVID-19 self-assessment										

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