Appendix C: Screening Tool

The screening must be done before **each OSHA-sanctioned activity including individual skills sessions, practices and games.**

Name:_____________________________ Date: ___________________ Time: ____________

Are you currently experiencing any of these symptoms?

Choose any/all that are new, worsening, and not related to other known causes or conditions you already have.

- ☐ **Fever and/or chills**
  Temperature of 37.8 degrees Celsius/100 degrees Fahrenheit or higher

- ☐ **Cough or barking cough (croup)**
  Continuous, more than usual, making a whistling noise when breathing (not related to asthma, post-infectious reactive airways, COPD, or other known causes or conditions you already have)

- ☐ **Shortness of breath**
  Out of breath, unable to breathe deeply (not related to asthma or other known causes or conditions you already have)

- ☐ **Decrease or loss of taste or smell**
  Not related to seasonal allergies, neurological disorders, or other known causes or conditions you already have

- ☐ **Sore throat or difficulty swallowing**
  Painful swallowing (not related to seasonal allergies, acid reflux, or other known causes or conditions you already have)

- ☐ **Runny or stuffy/congested nose**
  Not related to seasonal allergies, being outside in cold weather, or other known causes or conditions you already have

- ☐ **Pink eye (only applies to adults 18+)**
  Conjunctivitis (not related to reoccurring styes or other known causes or conditions you already have

- ☐ **Headache**
  Unusual, long-lasting (not related to ***getting a COVID-19 vaccine in the last 48 hours****, tension-type headaches, chronic migraines, or other known causes or conditions you already have)*

☐ **Digestive issues like nausea/vomiting, diarrhea, stomach pain**
Not related to irritable bowel syndrome, menstrual cramps, or other known causes or conditions you already have

☐ **Muscle aches/joint pain**
Unusual, long-lasting (not related to ***getting a COVID-19 vaccine in the last 48 hours****, a sudden injury, fibromyalgia, or other known causes or conditions you already have)*

☐ **Extreme tiredness or muscle aches**
Unusual, fatigue, poor feeding in infants (not related to ***getting a COVID-19 vaccine in the last 48 hours****, depression, insomnia, thyroid dysfunction, sudden injury, or other known causes or conditions you already have)*

☐ **Falling down often**
For older people

☐ **None of the above**

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1. Is anyone you live with currently experiencing any new COVID-19 symptoms and/or waiting for test results after experiencing symptoms? No Yes

   If you are fully vaccinated (it has been 14 or more days since your final dose of either a two-dose or a one-dose vaccine series), select "No."

   If the person got a COVID-19 vaccine in the last 48 hours and is experiencing a mild headache, fatigue, muscle aches, and/or joint pain that only began after vaccination, select "No."

2. In the last 14 days, have you travelled outside of Canada and been told to quarantine (per the federal quarantine requirements)? No Yes

3. In the last 14 days, have you been identified as a "close contact" of someone who currently has COVID- 19? No Yes

   If public health has advised you that you do not need to self-isolate (for example, you are fully vaccinated or for another reason), select "No."

4. In the last 14 days, has anyone you live with:
   - travelled outside of Canada and been told to quarantine (per the federal quarantine requirements)?; or

- been identified as a "close contact" of someone who currently has COVID-19 and been told to self-isolate by a doctor, healthcare provider, or public health unit? No Yes

If you are fully vaccinated, select "No".

5. Has a doctor, health care provider, or public health unit told you that you should currently be isolating (i.e., staying at home)? No Yes

   This can be because of an outbreak or contact tracing.

6. In the last 10 days, have you tested positive on a rapid antigen test or home-based self-testing kit? No Yes

   If you have since tested negative on a lab-based PCR test, select "No."

7. In the last 14 days have you received a COVID Alert exposure notification on your cell phone or via other means? No Yes

   If you are fully vaccinated (it has been 14 or more days since your final dose of either a two-dose or a one-dose vaccine series), select "No."

   If you already went for a test and got a negative result, select "No."

If you have any of the symptoms or answer YES to one or more of the questions, please self-isolate immediately and call your healthcare provider for further advice or assessment. A *Team Participant* is not allowed to participate in any hockey related activity or attend the facility unless cleared to do so by your healthcare provider or a COVID-19 Assessment Centre and you are symptom-free for 24 hours.