INNERACTIVE MARTIAL ARTS

STUDENT COVID-19 SCREENING FORM

PLEASE COMPLETE ON BEHALF OF STUDENT BEFORE START OF EACH CLASS

Click or tap to enter a date.

STUDENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. In the last 14 days have you or the student travelled outside of Canada?

[ ]  Yes [ ]  No

1. Have you tested positive for COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE?

[ ]  Yes [ ]  No

1. Do you have any ONE of the following symptoms? Fever, New Onset Cough, Worsening Chronic Cough, Shortness of Breath, Difficulty Breathing, Sore throat, Hoarse Voice, Difficulty Swallowing, Decrease or loss of sense of taste/smell, Chills, Headaches, Unexplained fatigue, Diarrhea, Abdominal Pain, Nausea/vomiting, Pink eye, Runny Nose/Sneezing without other known cause, Nasal Congestion without other known cause.

 [ ]  Yes [ ]  No

If you are feeling unwell or have any of the symptoms stated above, please refrain from attending class.

PARENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_