ONTARIO WOMEN'S HOCKEY ASSOCIATION

**Appendix C: HEALTH SCREENING FORM**

# HEALTH SCREENING QUESTIONAIRE

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.

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

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

1. 70 years old or older
2. Getting treatment that compromises, (weakens) your immune system (for example, chemotherapy, medication for transplants, corticosteroids, TNF inhibitors)
3. Having a condition that compromises (weakens) your immune system (for example, diabetes, emphysema, asthma, heart condition)
4. 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 each on-ice activity.**

**Participants Name: _____ Date & Time of Screening: _____**

**If Participant is a minor, name of parent / guardian who completed the screening: _____**

1. Are you experiencing any of these symptoms?

   Do you have a fever? (Feeling hot to the touch, a temperature of 37.8C or higher)
   ☐ Yes ☐ No

   Chills
   ☐ Yes ☐ No

   Cough that's new or worsening (continuous, more than usual)
   ☐ Yes ☐ No

   Barking cough, making a whistling noise when breathing (croup)
   ☐ Yes ☐ No

   Shortness of breath (out of breath, unable to breathe deeply)
   ☐ Yes ☐ No

   Sore throat
   ☐ Yes ☐ No

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**Participants Name: _____ Date & Time of Screening: _____**

**If Participant is a minor, name of parent / guardian who completed the screening: _____**

Difficulty swallowing
☐ Yes ☐ No

Runny nose, sneezing or nasal congestion (not related to seasonal allergies or other known causes or conditions)
☐ Yes ☐ No

Lost sense of taste or smell
☐ Yes ☐ No

Pink eye (conjunctivitis)
☐ Yes ☐ No

Headache that's unusual or long lasting
☐ Yes ☐ No

Digestive issues (nausea/vomiting, diarrhea, stomach pain)
☐ Yes ☐ No

Muscle aches
☐ Yes ☐ No

Extreme tiredness that is unusual (fatigue, lack of energy)
☐ Yes ☐ No

Falling down often
☐ Yes ☐ No

For young children and infants: sluggishness or lack of appetite
☐ Yes ☐ No

**For the remaining questions, close physical contact means: Being less than 2 meters away in the same room, workspace, or area for over 15 minutes 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?
   ☐ Yes ☐ No

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?
   ☐ Yes ☐ No

4. Have you travelled outside of Canada in the last 14 days?
   ☐ Yes ☐ No

**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 (June 17, 2020).*