GMHI (OHF) COVID-19 Pre-Screening Questionnaire

This form must be completed prior to entry into any facility. No verbal screening will be conducted due to time constraints.

Player Name:	
Date of Ice Time (MM/DD/YY):	
Start Time of Ice Time:	
Name of Person completing this form (if not player):	

This questionnaire must be completed by each individual prior to participation in each on-ice or off-ice activity.

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 any and all activity.
1. Are you currently 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
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 metres away in the same room, workspace, or area for over 15 minutes**
- **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).