SKATECANADA
COCHRANE SKATING CLUB

CANSKATE

Name of Skater_____ **Date**_____

1. Does the participant have any new onset (or worsening) of the following symptoms:

Fever yes / no Cough yes / not Shortness of Breath / Difficulty Breathing yes / no

Sore throat yes / no Chills yes / no Painful swallowing yes / no

Runny Nose / Nasal Congestion yes / no Feeling unwell / Fatigued yes / no

Nausea / Vomiting / Diarrhea yes/ no Unexplained loss of appetite yes / no

Loss of sense of taste or smell yes / no Muscle / Joint aches yes / no Headache yes / no

Conjunctivitis (commonly known as pink eye) yes/ no

2. Has the participant travelled outside of Canada in the last 14 days? yes / no

3. Has the participant had close contact* with a confirmed case of COVID-19 in the last 14 days? yes / no

*Face-to-face contact within 2 meters.

4. Has the participant had close contact with a symptomatic close contact of a confirmed case of COVID-19 in the last 14 days?** yes / no

** Symptomatic means someone with COVID-19 symptoms on the list above

Spectator's name(s)_____

Spectator's contact number_____