COVID SCREENING QUESTIONNAIRE

North River Riders

EFFECTIVE DATE:October 9, 2021

		YES	NO	
1. Do you have any of the following NEW OR WORSENING symptoms or signs. Symptoms should not be chronic or related to other known causes				
a. Fever or chills (a temperature of 38 C or higher (100.4 F)	1a.			
b. Difficulty breathing or shortness of breath	1b.			
c. Cough NEW OR WORSENING	1c.			
d. Sore throat or trouble swallowing NEW OR WORSENING	1d.			
e. Headache NEW OR WORSENING	1e.			
f. Runny nose/stuffy nose or nasel congestion NEW OR WORSENING	1f.			
g. Decrease or loss of smell or taste	1g.			
h. Nausea, vomiting, diarrhea, abdominal pain	1h.			
i. Not feeling well, unusual tiredness or extremely sore muscles	1i.			
j. Pink eye or conjunctivitis, not related to other known causes or conditions (for example reocurring styes)	1j.			
2. Have you travelled outside Canada in the last 14 days?	2			
3. Have you had close contact with a confirmed or probable case of Covid-19 in the past 14 days?	3			
4. Has a doctor, healthcare provider. or public heath unit told you to isolate (stay home)? or requested you to be tested?	4			
5. In the last 14 days have you received a COVID alert exposure notification on your cell? If you already went for a test and got a negative result check NO	5			
6. ** Are you OR a member of your household going for a COVID-19 test within the next 3 days or have been tested for COVID-19 in the last 5 days?	6			
IF YOU ANSWER YES TO ANY OF THE ABOVE QUESTIONS YOU MAY NOT ENTER THE PROPERTY. PLEASE NOTIFY LOCAL PUBLIC HEALTH OR YOUR FAMILY DOCTOR				
				Date
7. Have you received your 1st COVID-19 Vaccine	7			
8. Have you received you 2nd COVID -19 Vaccine	8			

NAME: _____ DATE _____ TIME _____

name all minors accompanying you to be filled in day of

NAME _____ AGE_____ NAME _____ AGE_____

NAME_____ AGE_____ NAME_____ AGE_____

PHONE NUMBER_____

SIGNATURE _____