



# BMHL FACILITY ENTRY SCREENING

ACTIVITY INFORMATION:				
Activity Date:		Start Time:		
Team:		End Time:		
Facility:		Rink/Pad:		
PARTICIPANT INFORMATION:				
First Name:		Last Name:		
Date of Birth:				
PARENT/GUARDIAN INFORMATION:				
First Name:		Last Name:		
Email:		Phone:		
COVID SCREENING QUESTIONS:				
Have you travelled outside of Canada or had close contact with anyone that has travelled outside of Canada in the past 14 days?	YES:		NO:	
Do you have any of the common symptoms of Covid-19 (i.e. fever, chills, headache, cough, fatigue, sore throat, or others – please see self screening questionnaire for more details.	YES:		NO:	
In the last 14 days, have you had close contact with anyone with respiratory illness or a confirmed or probable case of COVID-19?	YES:		NO:	

PLEASE NOTE: the full all participants must also complete the full Covid-19 Self Screening Questionnaire included with this document. By signing below you are attesting that you have completed the questionnaire, and have not answered to YES any of the individual questions.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date Signed:

# Covid-19 Self Screening Questionnaire

This self-assessment 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)

**Are you experiencing any of these symptoms? (The answer to all questions must be “No” in order to participate in any activity.)**

	YES	NO
Do you have a fever? (Feeling hot to the touch, a temperature of 37.8C or higher)		
Chills		
Cough that’s new or worsening (continuous, more than usual)		
Barking cough, making a whistling noise when breathing (croup)		
Extreme tiredness that is unusual (fatigue, lack of energy)		
Sore throat		
Difficulty swallowing		
Falling down often		

	YES	NO
Runny nose, sneezing or nasal congestion (not related to seasonal allergies or other known conditions)		
Headache that’s unusual or long lasting		
Digestive issues (nausea/vomiting, diarrhea, stomach pain)		
Shortness of breath (out of breath, unable to breathe deeply)		
For young children and infants: sluggishness or lack of appetite		
Lost sense of taste or smell		
Pink eye (conjunctivitis)		
Muscle aches		

**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.**

	YES	NO
In the last 14 days, have you been in close physical contact with someone who tested positive for COVID-19?		
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?		
Have you travelled outside of Canada in the last 14 days?		

**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.**