Winnipeg Gliding Club

COVID-19 SCREENING TOOL - Check the Appropriate Box for each question.

Do you have any of the following symptoms?		
Severe Difficulty Breathing	YES	NO
Chest Pain	YES	NO
Confusion	YES	NO
Extreme Drowsiness	YES	NO
Loss of Consciousness	YES	NO
Do you have shortness of breath at rest or difficulty breathing when lying down?		
	YES	NO
Do you have a new onset of any of the following syptoms?		
Fever / Chills	YES	NO
Cough	YES	NO
Sore Throat / Hoarse Voice	YES	NO
Shortness of Breath	YES	NO
Loss of Taste or Smell	YES	NO
Vomitting or Diarrhea for more than 24 hours	YES	NO
Do you have a new or onset of 2 or more of any of the following symptoms?		
Runny Nose	YES	NO
Muscle Aches	YES	NO
Fatigue	YES	NO
Conjuncivitis (Pink Eye)	YES	NO
Headache	YES	NO
Skin Rash of Unknown Cause	YES	NO
Nausea or Loss of Appetite	YES	NO
Have you been in close contact in the last 14 days with someone that is confirmed to have COVID-19?		
	YES	NO
Have you had laboratory exposure while working directly with specimens known to contain COVID-19?		
	YES	NO
Have you been in a setting in the last 14 days that has been identified by public health as a risk for aquiring COVID-19, such as on a fligtht, in a workplace or community with a cluster of cases, or at an event?		
	YES	NO
Have you travelled outside of Canada, or within Canada excluding travel to western Canada and the Territories or Ontario west of Terrace Bay in the last 14 days?		
	YES	NO
In the last 14 days has anyone living in your household travelled outside of Canada, or within Canada excluding travel to western Canada, the Territories or Ontario west of Terrace Bay?		
	YES	NO

PRINT NAME	**DATE**	**SIGNATURE**