City of Stratford Facility Entrance Required Screening – Dufferin Arena

Name (Adult):	**Date:**
Name (Adult):	**Phone #:**
Name (Child Participant):	**Time Entered:**
Name (Child Participant):	

1. **Do you have any of the following new or worsening symptoms or signs?**
   - Fever and/or chills
   - Cough or barking cough
   - Shortness of breath
   - Decrease or loss of smell or taste
   - Sore throat or difficulty swallowing
   - Pink eye
   - Runny or stuffy/congested nose
   - Headache
   - Nausea/vomiting, diarrhea
   - Stomach pain
   - Extreme tiredness
   - Muscle aches
   - Falling down often

   Adult ☐ yes ☐ no
   Adult ☐ yes ☐ no
   Child Participant ☐ yes ☐ no
   Child Participant ☐ yes ☐ no

2. **Have you travelled outside of Canada in the last 14 days? If you are an essential worker who crosses the Canada-US border regularly for work, select "No".**

   Adult ☐ yes ☐ no
   Adult ☐ yes ☐ no
   Child Participant ☐ yes ☐ no
   Child Participant ☐ yes ☐ no

3. **In the last 14 days, has a public health unit identified you as a close contact of someone who currently has Covid-19?**

   Adult ☐ yes ☐ no
   Adult ☐ yes ☐ no
   Child Participant ☐ yes ☐ no
   Child Participant ☐ yes ☐ no

4. **Has a doctor, health care provider, or public health unit told you that you should currently be isolating (staying at home)?**

   Adult ☐ yes ☐ no
   Adult ☐ yes ☐ no
   Child Participant ☐ yes ☐ no
   Child Participant ☐ yes ☐ no

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, select "No".**

   Adult ☐ yes ☐ no
   Adult ☐ yes ☐ no
   Child Participant ☐ yes ☐ no
   Child Participant ☐ yes ☐ no

If you answer YES to any one of the questions above, PLEASE DO NOT enter this location AND contact your health care provider or Telehealth Ontario (1-866-797-0000) to get advice or an assessment, including if you need a COVID-19 test.