***YORK CENTRE KARATE***

## ***COVID-19 Screening Checklist***

Student Name:_____

Parent Name:_____

**Have you had any of the following symptoms in the last 24 hours?**

| | | |
|---|---|---|
| Cough: | Yes | No |
| Shortness of breath | Yes | No |

**Or at least two of the following symptoms in the last 24 hours?**

| | | |
|---|---|---|
| Fever 38 or higher | Yes | No |
| Chills | Yes | No |
| Repeated shaking with chills | Yes | No |
| Muscle pain | Yes | No |
| Headache | Yes | No |
| Sore throat | Yes | No |
| Runny or stuffy nose | Yes | No |
| New loss of taste or smell | Yes | No |

**In the last 14 days have you:**

| | | |
|---|---|---|
| Been in contact with someone who was diagnosed with COVID-19? | Yes | No |
| Been in close contact with someone who had COVID-19 symptoms? | Yes | No |
| Traveled internationally or taking a cruise? | Yes | No |

Date:_____ Signature:_____