**SYC Essential Maintenance-Volunteer Screening**

All work groups must be actively screened either before arrival at the club, or before they start the work day in accordance with Public Health Guidelines. You will need to fill in this form EVERY DAY you participate in essential maintenance, and hand it in to your crew leader. This information is required to be kept for a minimum of 30 days for contact tracing purposes.

WORKER NAME & SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WEEK OF:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following new or worsening symptoms or signs? Symptoms should not be chronic or related to other known causes or conditions. Indicate with an X for no, a ✓ for yes

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Symptom** | Mon | Tues | Wed | Thur | Fri | Sat | Su |
| Fever or chills – 37.8 C/100° F or higher  |  |  |  |  |  |  |  |
| Cough or barking cough not related to other known conditions |  |  |  |  |  |  |  |
| Shortness of breath not related to other known conditions |  |  |  |  |  |  |  |
| Sore throat, trouble swallowing not related to allergies or other known conditions |  |  |  |  |  |  |  |
| Decrease or loss of smell or taste not related to seasonal allergies, neurological disorders or other known causes or conditions |  |  |  |  |  |  |  |
| Runny/Stuffy/Congested Nose not related to seasonal allergies, being outside in cold or other known causes or conditions |  |  |  |  |  |  |  |
| Headache – unusual, long-lasting not related to tension-type headaches, chronic migraines or other known causes or conditions |  |  |  |  |  |  |  |
| Digestive Issues – nausea/vomiting, diarrhea, stomach pain not related to IBS, menstrual cramps or other known causes or conditions |  |  |  |  |  |  |  |
| Muscle Aches/joint pain – unusual, long lasting not related to other known conditions |  |  |  |  |  |  |  |
| Extreme tiredness – unusual fatigue, lack of energy (not related to other known causes) |  |  |  |  |  |  |  |
| In the last 10 days, has someone you live with been sick with symptoms associated with COVID-19, and/or tested positive for COVID-19 (on a rapid antigen test or PCR test)? |  |  |  |  |  |  |  |
| In the last 10 days, have you tested positive on a rapid antigen test of home-based self-testing kit? |  |  |  |  |  |  |  |
| In the last 10 days, have you received a COVID alert exposure notification on your cell phone? |  |  |  |  |  |  |  |
| In the last 10 days, have you been identified as a “close contact” of someone who currently has COVID-19 (confirmed by a PCR or rapid antigen test)? |  |  |  |  |  |  |  |
| In the last 14 days, have you travelled outside of Canada? |  |  |  |  |  |  |  |
| **Please Initial Here at the start of the day** |  |  |  |  |  |  |  |

If you answered **YES** (✓)to any of the above screening questions, **do NOT enter SYC** and consult your healthcare provider for further instructions.