Delta Community Music School
The Gift of Music for Life

COVID-19 SCREENING CHECKLIST

Name_____ **Date:** _____ **Your Temperature** _____

Please select all that apply to you.

☐ Have you tested positive for COVID-19 or are you awaiting results for a COVID-19 test?

Do you have any of the following cold or flu-like symptoms (even mild ones):

☐ Cough
☐ Shortness of Breath
☐ Sore throat or painful swallowing
☐ Stuffy or Runny Nose
☐ Loss of sense of smell
☐ Headache
☐ Muscle Ache
☐ Fatigue
☐ Loss of appetite
☐ Fever
☐ Gastrointestinal issues, or abdominal pain
☐ conjunctivitis (pink eye), dizziness, skin rashes or discoloration of fingers or toes.

Are you experiencing any of the following?

☐ Severe difficulty breathing
☐ Severe chest pain
☐ Having a very hard time waking up
☐ Feel confused
☐ Losing Consciousness
☐ Have you travelled outside of Canada in the past 14 days?

☐ No to all above

Signature _____