Bradford Soccer Club
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Health Questionnaire

Name: _____ __ **Date of Birth**____/____/____

This Questionnaire Will Need to Be Completed for **EVERY** Training Session

Please the **DELETE** the relevant option.

Do you have any of the below symptoms?			
1	a. Fever (greater than 38.0 C)?	YES	NO
	b. Cough?	YES	NO
	c. Shortness of breath / difficulty breathing?	YES	NO
	d. Sore throat?	YES	NO
	e. Runny nose?	YES	NO
2	Has anyone in your household experienced any of the above symptoms in the last 14 days?	YES	NO
3	Have you, or anyone in your household travelled outside of Canada in the last 14 days?	YES	NO
4	Have you, or anyone in your household been in contact in the last 14 days with someone who is being investigated as a suspected case of COVID-19?	YES	NO
5	Are you currently being investigated as a suspected case of COVID-19?	YES	NO
6	Have you tested positive for COVID-19within the last 10 days?	YES	NO

If an individual answers "YES" to any of the above questions, they are not permitted to participate in any in-personsoccer activity for a minimum of 14 days.