Great Lakes Sea Kayaking Association

COVID-19 Screening for Trip: _____

In order to keep everyone safe and limit the spread of COVID-19, I ask you to read this document carefully and answer the questions below. Please return the completed questionnaire by _____.

Name: _____

Phone Number:_____

Date: _____

Yes _____ No _____ Do you have any of the following: Fever/chills, cough that is new or worsening, shortness of breath/difficulty breathing/unable to breathe deeply, sore throat of difficulty swallowing, runny nose (unrelated to seasonal allergies or other known conditions), loss of sense of taste or smell, headache, digestive issues (nausea, vomiting, diarrhea and/or stomach pain), unexplained muscle aches or extreme tiredness or fatigue, feeling unwell?

Yes _____ No _____ Have you been in close contact (within 6' in the same room, workspace, or area for over 15 minutes) with someone who is sick with a new cough, fever or difficulty breathing or has confirmed COVID-19 in the past 14 days?

Yes _____ No _____ Have you returned from travel outside Canada in the past 14 days?

If you received either a COVID-1 Virus or Antigen test, please provide the following information:

Test Type: _____

Test Date: _____

Test Results: _____