Name of Participant:_____

Date: _____

1. Please ensure you and your child are NOT experiencing any of the following:
   - Fever
   - Cough
   - Shortness of breath
   - Sore throat
   - Severe chest pain
   - Having a hard time waking up
   - Feeling confused
   - Lost consciousness
   - Inability to lie down because of difficulty breathing
   - Headache
   - Muscle and/or joint pain or fatigue
   - Chills
   - Runny nose/ nasal congestion
   - Conjunctivitis
   - Vomiting or diarrhea
   - Loss of sense of smell or taste
   - Chronis health conditions that you are having difficulty managing because of your current respiratory illness

Initial_____

2. You or your child participating in classes have not been exposed to someone who is under investigation or under suspicion of having COVID-19 within the last 14 days

Initial_____

3. In the past 14 days you or your child participating in classes have not travelled internationally or to a location known to have elevated cases of COVID-19

Initial_____

I have had sufficient opportunity and time to read this entire document. I have read and understood it, and I have answered “No” to all of the questions. By initialling, you are answering “No” to each of the following COVID-19 screening questions. To be eligible to participate in any We Move SK classes, all answers above must be “No” and initialled.