Association of SHOTOKAN KARATE 空手

Name (Individual or all family members training):
Date:

1. Do you currently have any of the following symptoms, Fever, Cough, Shortness of breath, Sore Throat, Chills, Painful swallowing, Runny nose or nasal congestion, Feeling unwell or Fatigue, Nausea, Vomiting or Diarrhea, Unexplained loss of Appetite, Loss of taste or small, muscle or joint aches, headache?

YES NO

2. Have you, or anyone in your household, travelled outside of Canada in the last 14 days?

YES NO

3. Have you, or your children attending the program has close unprotected contact (face-to-face contact within 2 meter /6 feet) with someone who is ill with cough and/or fever?

YES NO

4. Have you or anyone in your household been in close unprotected contact in the last 14 days with someone who is being investigated or confirmed to be a case of COVID-19?

YES NO

ASSOCIATION OF
SHOTOKAN KARATE

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