Participant Name: _____ Birthday: _____

Parent/Guardian: _____ Phone: _____

Email: _____ Today's date: _____

COVID-19 Screening

Temperature: _____

Close physical contact means: Being less than 2 metres away in the same room, workspace, or area for over 15 minutes or living in the same house

Have you travelled outside of Ontario in the last 14 days?	▢ Yes	▢ No
In the last 14 days, have you been in close physical contact with a person who is currently sick with a new cough, fever, or difficulty breathing?	▢ Yes	▢ No
In the last 14 days, have you been in close physical contact with a person who returned from outside of Canada within the last 2 weeks?	▢ Yes	▢ No
In the last 14 days, have you been in close physical contact with someone who tested positive for COVID-19?	▢ Yes	▢ No

Are you currently experiencing any of these issues? Call 911 if you are. Check all that apply.

- ☐ Severe difficulty breathing - struggling for each breath, can only speak in single words
- ☐ Severe chest pain - constant tightness or crushing sensation
- ☐ Feeling confused or unsure of where you are
- ☐ Losing consciousness
- ☐ None of the above

PLEASE TURN OVER AND COMPLETE PAGE 2.

Are you currently experiencing any of these symptoms? Check all that apply.

- ☐ Fever (feeling hot to the touch, a temperature of 37.8 degrees Celsius or higher)
- ☐ Chills
- ☐ Cough that is new or worsening (continuous, more than usual)
- ☐ Lost sense of taste or smell
- ☐ Shortness of breath (out of breath, unable to breathe deeply)
- ☐ Sore throat
- ☐ Runny nose (not related to seasonal allergies or other known causes or conditions)
- ☐ Difficulty swallowing
- ☐ Barking cough, making a whistling noise when breathing (croup)
- ☐ Pink eye (conjunctivitis)
- ☐ Digestive issues (nausea/vomiting, diarrhea, stomach pain)
- ☐ Headache that's unusual or long lasting
- ☐ Extreme tiredness that is unusual (fatigue, lack of energy)
- ☐ Muscle aches (not sport related)
- ☐ For young children and infants: sluggishness or lack of appetite
- ☐ Falling down often
- ☐ None of the above

Birthday Party Waiver

Medical Record: Does the child have a history of allergies, asthma, bone/joint injury, hearing/vision impairment, or any other physical disability? If yes, please explain:

_____

_____

Amateur Athletic Waiver

In consideration of being allowed to participate at AIM Gymnastics with regards to athletic/sports programs, related events and activities, the undersigned individual acknowledges, appreciates, and agrees that: As in any sport the possibility of injury exists and while particular rules, equipment, and personal discipline may reduce the risk, the risk of injury does exist.

Information Release

By participating in programs at AIM Gymnastics, AIM Gymnastics/Gymnastics Ontario/Gymnastics Canada has the right to take photographs, videotape or digital recording and to use these in any and all print and social media, including AIM Gymnastics /Gymnastics Ontario/Gymnastics Canada websites.

_____ _____

(Signature of participant or parent/guardian if under 18) (Date)