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Empowering People to TAKE ACTION

COVID-19 Participant Screening Questionnaire

Action First Aid is committed to doing their part in keeping everyone safe and healthy during the time of COVID-19.

We ask that you complete the questionnaire and consent form below with your course instructor prior to your course.

If at any time during the course you are feeling unwell, coughing, sneezing or the instructor is concerned about your health you may be asked to leave the course for the safety of others.

Thank you for your continued support and patience,

Your friends at Action First Aid

Name: _____ **Date**: _____

1. Do you have the following symptoms: fever, and/or cough or difficulty breathing?

YES / NO

2. Have you travelled out of the country in the past 14 days or been in close contact with someone who has?

YES / NO

3. Have you been in contact with anyone who has been self-isolating?

YES / NO

Day 2 of Training. To be signed only on day 2 of training.

Name: _____ **Date**: _____

I consent that I am still symptom free, have not travelled out of the country in the past 14 days or have not been in contact with anyone who has been self-isolating.

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CONSENT TO RELEASE OF PERSONAL INFORMATION

I understand that it is a condition of my attending a course with Action First Aid that I will provide my name, telephone number, email address, and address to Action First Aid staff. I understand that the purpose of collecting, using, and disclosing this information is to protect the health and safety of staff and visitors to Action First Aid and any use and disclosure shall be in accordance with the terms of this consent.

In the event Action First Aid becomes aware that I have been diagnosed with or developed symptoms of COVID-19, I consent to Action First Aid notifying all individuals with whom I had contact with at Action First Aid. I understand that notification will consist solely of advising these individuals that they were in contact with someone who was subsequently diagnosed with or developed symptoms of COVID-19 and that my personal information will not be disclosed.

In the event Action First Aid becomes aware that I have been diagnosed with or developed symptoms of COVID-19, I further consent to Action First Aid releasing my name, telephone number, email address, and address to the applicable local public health authorities. I understand that any such disclosure will be limited to my name, telephone number, email address, and address.

In the event an individual with whom I had contact during my visit at Action First Aid is diagnosed with or develops symptoms of COVID-19, I consent to receiving notification by email, telephone, or other available means of communication.

Date: _____

Email: _____

Print Full Name: _____

Signature: _____

Phone Number: _____

Address: _____