



**FIREARMS SAFETY EDUCATION SERVICE OF ONTARIO  
ADMINISTRATION OFFICE**  
3 Progress Dr. Unit 2,  
Orillia, ON L3V 0T7  
Admin Phone: 1-877-322-2345  
Fax: 705-325-9193

## **PARTICIPANT SELF-SCREENING CHECKLIST**

To help prevent the spread of COVID-19 and reduce the potential risk of exposure to the CFSC/CRFSC participants and instructor(s), we are conducting a simple screening questionnaire. Your participation is important to help us take precautionary measures to protect you and everyone attending the course.

**Thank you for your time and cooperation.**

---

### **Contact information:**

**Name:**

**Mobile Number:**

**Email Address:**

### **Have you experienced a new onset of one or more of the following symptoms?**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| New or worsening cough                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shortness of breath                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sore throat                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Runny nose or sneezing                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nasal congestion                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hoarse voice                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty swallowing                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| New smell or taste disorder(s)            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nausea/vomiting, diarrhea, abdominal pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Unexplained fatigue/malaise               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chills                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Headache                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fever (37.8 °C or higher)                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Have you been in close contact with someone with COVID-19?**  Yes  No

**Have you been notified that you were in a high risk setting for COVID-19 in the past 14 days?**  Yes  No

**Have you travelled outside Canada within the last 14 days?**  Yes  No

***If you have any questions or concerns regarding any of the above screening questions, please contact your instructor directly.***

**Anyone making false or misleading statements with respect to the above questions will be removed from the course immediately without refund.**