GWSA TRIP INFORMATION – Bring this completed sheet with you.

Accidents and illnesses happen all too often, and as we age the possibilities can increase. When you take a GWSA trip it's important we are able to provide a safe environment for you, our friends. That's why it's important that you bring certain things with you on these trips. This is your private information and you won't need to give it to us. However, if you need medical assistance during the trip it will be important to have this information available to give to medical personnel.

Name: _____

1) Proper Identification i.e. driver's license, passport

2) The name and phone number of an emergency contact who's not on the trip with you:

Name: _____ Phone: _____

3) Your Ontario Health Card

4) Your Family Doctor's Name and Phone number

Name: _____ Phone: _____

5) A list of known major health issues:

_____

_____

_____

6) A list of all medications you take

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

7) A list of any/all allergies particularly regarding food or medication that may cause you to have a life-threatening reaction.

Allergies: _____

_____

_____

8) Your emergency medical equipment i.e. epi-pen

It's also important for you to know that if you experience a major health issue or accident on a trip we are obliged to contact a health professional such as an EMT or ambulance for an assessment. This is a liability issue for the GWSA.

GWSA COVID – 19 Screening Questions
NOTE: THIS SHEET IS TO BE COMPLETED THE MORNING OF THE TRIP

Name:_____

Q1: Did you travel outside of Canada in the past 14 days?
☐ YES ☐ NO

Q2: Has the person tested positive for COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE?
☐ YES ☐ NO

Q4: Does the person have any of the following symptoms?

• **Fever**	☐ YES	☐ NO
• **New onset of cough**	☐ YES	☐ NO
• **Worsening chronic cough**	☐ YES	☐ NO
• **Shortness of breath**	☐ YES	☐ NO
• **Difficulty breathing**	☐ YES	☐ NO
• **Sore throat**	☐ YES	☐ NO
• **Difficulty swallowing**	☐ YES	☐ NO
• **Decrease of loss of sense of taste or smell**	☐ YES	☐ NO
• **Chills**	☐ YES	☐ NO
• **Headaches**	☐ YES	☐ NO
• **Unexplained fatigue/malaise/muscle aches (myalgias)**	☐ YES	☐ NO
• **Nausea/vomiting, diarrhea, abdominal pain**	☐ YES	☐ NO
• **Pink eye (conjunctivitis)**	☐ YES	☐ NO
• **Runny nose or nasal congestion without other known cause**	☐ YES	☐ NO

Q5: If the person is 70 years of age or older, are they experiencing any of the following symptoms?

• **Delirium**	□ YES	□ NO
• **Unexplained or increased number of falls**	□ YES	□ NO
• **Acute functional decline**	□ YES	□ NO
• **Worsening of chronic conditions**	□ YES	□ NO

COVID Results

If response to **ALL** of the screening questions is **NO**: **COVID Screen Negative**
If response to **ANY** of the screening questions is **YES**: **COVID Screen Positive**

Date:_____ **Signature:**_____