



COVID-19 SCREENING

Name: _____

Date: _____ Time: _____

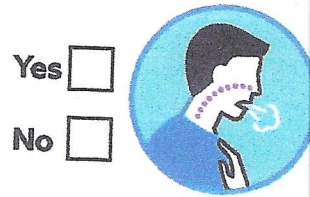
Do you have any of the following:



Fever



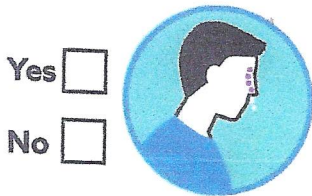
Cough



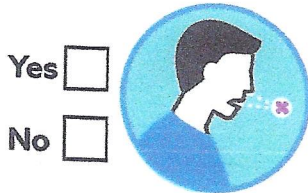
Difficulty breathing



**Sore throat,
trouble swallowing**



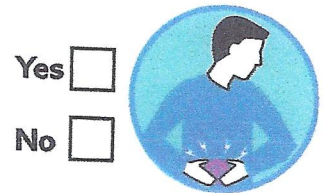
Runny nose



**Loss of taste or
smell**



Not feeling well



**Nausea, vomiting,
diarrhea**

Yes Have you been in close contact with someone who is
No sick or has confirmed COVID-19 in the past 14 days?

Yes Have you returned from travel outside Canada in the
No past 14 days?

If you answered YES to any of these questions, go home and self-isolate right away. Call Telehealth or your health care provider, to find out if you need a test.