COVID-19 SCREENING

Name: _____

Date: _____ Time: _____

Do you have any of the following:

Yes ☐ No ☐

Fever

Yes ☐ No ☐

Cough

Yes ☐ No ☐

Difficulty breathing

Yes ☐ No ☐

Sore throat, trouble swallowing

Yes ☐ No ☐

Runny nose

Yes ☐ No ☐

Loss of taste or smell

Yes ☐ No ☐

Not feeling well

Yes ☐ No ☐

Nausea, vomiting, diarrhea

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

Yes ☐ No ☐ Have you returned from travel outside Canada in the 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.