



COVID-19

Please complete before beginning your work today.

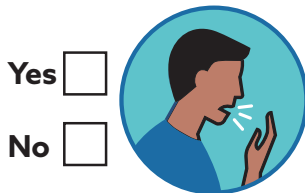
Name: _____ Date: _____ Time: _____

1.) Do you have any of the following new or worsening symptoms or signs?*



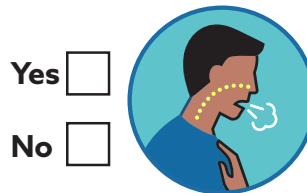
Yes
No

Fever or chills



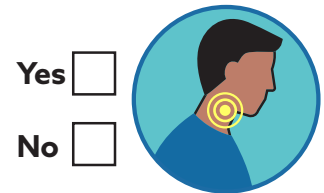
Yes
No

Cough



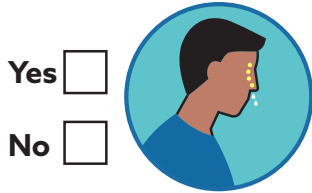
Yes
No

Difficulty breathing or shortness of breath



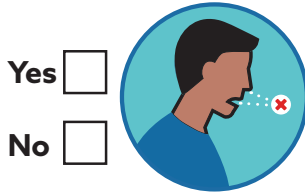
Yes
No

Sore throat, trouble swallowing



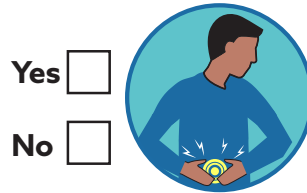
Yes
No

Runny/stuffy nose



Yes
No

Decrease or loss of taste or smell



Yes
No

Nausea, vomiting, diarrhea



Yes
No

Not feeling well, extreme tiredness, sore muscles

2.) Have you had close contact with a confirmed or probable case of COVID-19 without wearing appropriate PPE? Yes No

3.) Have you travelled outside of Canada in the past 14 days? Yes No

* If you have an existing health condition that gives you the symptoms you should not answer YES, unless the symptom is new, different or getting worse. Look for changes from your normal symptoms.

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

If you answered NO to all of these question, you have passed and can go to work/attend your activity.

The following questions are used to screen for COVID-19 before entry into a workplace (business or organization) as per Ontario Regulation 364/20. They can also be used for other activities.