STOP 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.