



COVID-19

Please complete the following questions before beginning your work today.

Name: _____

Date: _____ Time: _____

Do you have any of the following:



Yes

No

Fever



Yes

No

Cough



Yes

No

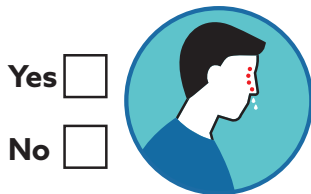
Difficulty breathing



Yes

No

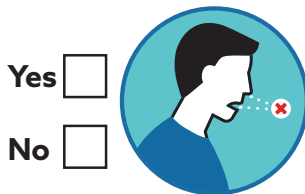
Sore throat,
trouble swallowing



Yes

No

Runny nose



Yes

No

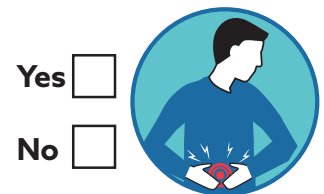
Loss of taste or
smell



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 & self-isolate right away. Call Telehealth or your health care provider, to find out if you need a test.