COVID-19 NOVEL CORONAVIRUS

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 ☐

Shortness of Breath

Yes ☐ No ☐

Sore Throat

Yes ☐ No ☐

Runny Nose

Yes ☐ No ☐

Feeling Unwell

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.