Name:		Date:	_ Time:
.) 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	Yes No	Yes No	Yes No
Runny/stuffy	Decrease or loss	Nausea, vomiting,	Not feeling well

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

diarrhea

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

of taste or smell

* 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.

extreme tiredness, sore muscles

nose