



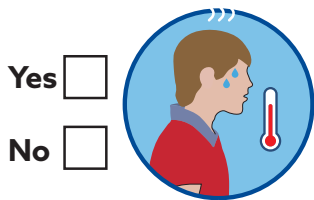
COVID-19

Please complete before entering the school.

Name: _____

Date: _____ Time: _____

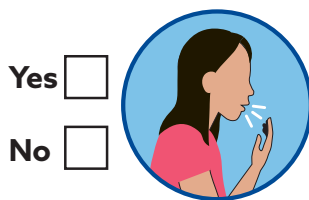
Do you have any of the following (new or worsening):



Yes

No

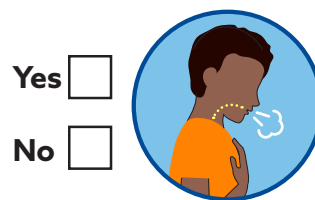
Fever



Yes

No

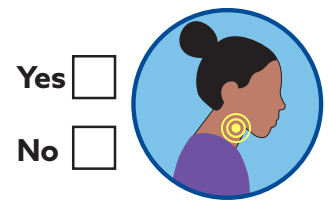
Cough



Yes

No

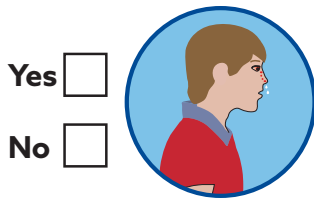
Difficulty breathing



Yes

No

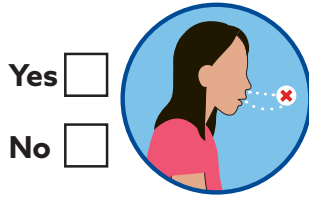
Sore throat, trouble swallowing



Yes

No

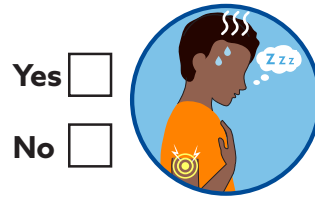
Runny nose or red eyes



Yes

No

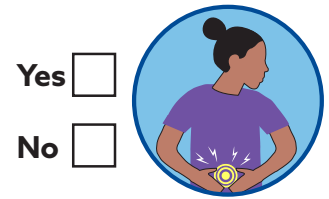
Loss of taste or smell



Yes

No

Not feeling well, tired or sore muscles



Yes

No

Nausea, vomiting, diarrhea

Yes

No

Have you been in close contact with someone who has confirmed COVID-19 in the past 14 days without wearing appropriate PPE?

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.